Supreme Court, U.S.
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In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS
OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND
THE COMMONWEALTH OF PENNSYLVANIA MEDICAL
PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of Pennsylvania

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether ERISA preempts a state tort action challenging a health maintenance organization's determination, under an ERISA-governed health plan, that a subscriber was eligible for coverage for services from a participating rather than a non-participating provider in the HMO's network.

RULE 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner United States Healthcare Systems of Pennsylvania, Inc., states that the other parties to this action are Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund. Basile Pappas and Theodora Pappas were plaintiffs in the trial court, but their claims against defendants Dr. David S. Asbel and Haverford Community Hospital were settled. App., *infra*, 46a n.2. As a result of the settlement, Mr. and Mrs. Pappas and Dr. Asbel are no longer parties to this litigation. After the settlement, respondents Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Fund, who were the insurers for defendant Haverford Community Hospital, were substituted as the real parties in interest for the Hospital. *Ibid.*

Pursuant to Rule 29.6, petitioner states that the ultimate parent company of United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"), is Aetna Inc., a Pennsylvania corporation. U.S. Healthcare does business as the Health Maintenance Organization of Pennsylvania and Aetna U.S. Healthcare; it has no subsidiaries.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the Supreme Court of Pennsylvania in this case.

OPINIONS BELOW

The opinion of the Supreme Court of Pennsylvania on remand (App., *infra*, 1a-29a) is reported at 768 A.2d 1089. The prior opinion of the Supreme Court of Pennsylvania (App., *infra*, 30a-42a) is reported at 555 Pa. 342, 724 A.2d 889. The opinion of the Pennsylvania Superior Court reinstating the third-party complaint by defendant Haverford Community Hospital against petitioner (App., *infra*, 43a-55a) is reported at 450 Pa. Super. 162, 675 A.2d 711. The opinion of the Court of Common Pleas of Delaware County granting petitioner's motion for summary judgment on the third-party complaint (App., *infra*, 56a-65a) is unreported.

JURISDICTION

The Supreme Court of Pennsylvania rendered its decision on remand on April 3, 2001. App., *infra*, 1a. On June 18, 2001, Justice Souter extended the time within which to file a petition for a writ of certiorari to and including August 1, 2001. This Court's jurisdiction is invoked under 28 U.S.C. § 1257. See *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469, 482-483 (1975).[1]

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[1] On the prior occasion when this case came before this Court, in the exact same procedural posture as this occasion, respondent extensively challenged this Court's jurisdiction. Not only did petitioner demonstrate in its reply brief that this Court had jurisdiction, but also the Solicitor General, in his Court-invited amicus brief filed on December 17, 1999, expressly "agreed with petitioner * * * that this case meets the four requirements for immediate appellate review under *Cox*." 98-1836 U.S. Br. 7 n.4. The Court ultimately granted certiorari and vacated the judgment below. *United States Healthcare Sys. of Pennsylvania, Inc.* v. *Pennsylvania Hospital Ins. Co.*, 530 U.S. 1241 (2000). The Court's order was a standard "GVR" order and did not mention jurisdiction, but of course the Court could not have taken the

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; * * * any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. Art. VI, cl.2.

Section 502(a) of ERISA states that "[a] civil action may be brought * * * (1) by a participant or beneficiary * * * (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; * * * (3) by a participant, beneficiary, or fiduciary * * * (B) to obtain other appropriate equitable relief (I) to redress such violations [of this subchapter or the terms of the plan] or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a).

Section 514(a) of ERISA states that "the provisions of this title * * * shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

STATEMENT

A. Factual Background

Basile Pappas was a subscriber of the Health Maintenance Organization of Pennsylvania ("HMO Pa."), a subsidiary of petitioner, through an employee welfare benefit plan provided to his wife by her employer. App., *infra*, 57a-58a. HMO Pa. administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for

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action it did without satisfying itself of its own jurisdiction first. See *ASARCO, Inc.* v. *Kadish*, 490 U.S. 605, 621 n.1 (1989) (Court lacks "the power to disturb the state court's judgment," even summarily, when "we lack jurisdiction").

a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

On May 20, 1991, Mr. Pappas went to his primary-care physician, Dr. David Asbel, complaining of neck and shoulder pain. App., *infra*, 57a. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of steroids. *Id.* at 44a. The next morning, Mr. Pappas was unable to walk and was experiencing numbness in his extremities. *Ibid.* He was transported by ambulance to Haverford Community Hospital. *Id.* at 57a. The emergency room physician at Haverford, Dr. Steven Dickter, diagnosed Mr. Pappas as suffering from an epidural abscess that pressed on his spinal column. *Id.* at 58a. Dr. Dickter concluded that Mr. Pappas should be treated at a "university" hospital, which would have more extensive facilities than Haverford. *Ibid.*

Dr. Dickter decided to transfer Mr. Pappas to Jefferson University Hospital. App., *infra*, 58a. When the ambulance arrived at Haverford at 12:40 p.m. to pick up Mr. Pappas, Dr. Dickter was informed by the ambulance personnel that Jefferson was not an HMO Pa. participating hospital, meaning that it was not one of the hospitals with which HMO Pa. contracts to provide hospital services to its plan members. *Ibid.* At 12:50 p.m., Dr. Dickter telephoned HMO Pa. to inquire as to Jefferson's status with HMO Pa. *Id.* at 44a.

The record reflects that Dr. Dickter spoke only with administrative — not medical — personnel of HMO Pa. Pa. Super. Ct. App. 67a-68a (deposition of Dr. Dickter at 47-52). The record further reflects that HMO Pa. administrative personnel consulted with their superior, the HMO's medical director, Dr. Leibowitz. *Ibid.* There is, however, no record of the considerations Medical Director Leibowitz took into account, or the information that was presented to him, in deciding whether to authorize treatment at Jefferson, because the parties opted not to depose Medical Director Leibowitz or to ask such questions of the administrative personnel who consulted with him.

Within fifteen minutes, HMO Pa. advised Dr. Dickter that coverage would not be provided for treatment at Jefferson, since it was not a participant in HMO Pa.'s network, but that there were three HMO Pa. participating university hospitals in the vicinity (Temple University, Hahnemann University, and Medical College of Pennsylvania) to which Mr. Pappas could be transferred. App., *infra*, 44a. No allegation has been made that these three hospitals were inferior to Jefferson, or that they were not appropriately equipped and staffed to treat Mr. Pappas' medical condition.

Thereafter, Dr. Dickter of Haverford called Dr. Asbel, Mr. Pappas's primary physician, to ascertain Dr. Asbel's preference concerning his patient's destination. App., *infra*, 58a. Dr. Asbel expressed a preference for Hahnemann, but Hahnemann delayed in responding to Dr. Dickter's request concerning its intensive care unit bed space availability. App., *infra*, 58a-59a. At approximately 2:20 p.m., Hahnemann called Dr. Dickter and advised him that it would be at least 30 more minutes before Hahnemann could determine whether it had space for Mr. Pappas. *Id.* at 59a Dr. Dickter then called Medical College of Pennsylvania, where Mr. Pappas was transported. *Ibid.*

Mr. Pappas and his wife brought a medical malpractice action against Dr. Asbel and Haverford, alleging that their delay in transferring Mr. Pappas to a hospital capable of treating his condition caused his spinal cord compression to continue and led to quadriplegia. App., *infra*, 6a n.2. Mr. and Mrs. Pappas did not sue petitioner. Haverford then filed a third-party complaint for contribution and indemnification against petitioner, complaining that it had "refused to authorize transfer of [Mr. Pappas] to a hospital selected by physicians at Haverford Community Hospital," namely Jefferson. Third-Party Cplt. ¶ 7. Haverford also incorporated the allegation in the Pappases' complaint that there was an inordinate delay in transferring Mr. Pappas from Haverford to a more suitable hospital. *Id.* ¶ 6.

B. Procedural History

1. After discovery, petitioner moved for summary judgment on the third-party complaint by Haverford on the ground that all of Haverford's claims are preempted by Section 514(a) of ERISA. The trial court granted the motion, stating that Haverford's allegations against petitioner "fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision." App., *infra*, 62a. The trial court further observed: "Haverford Hospital seems to suggest that [petitioner] is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under [petitioner's] programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan." App., *infra*, 64a.

The plaintiffs' claims against Dr. Asbel and Haverford were settled. The trial court then entered an order substituting Haverford's insurers, respondents Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund (the "CAT Fund"), for Haverford as the real parties in interest to the claim for contribution or indemnification. App., *infra*, 46a n.2.

2. PHICO and the CAT Fund appealed the summary judgment order to the Pennsylvania Superior Court, which reversed. The Superior Court acknowledged that what was at issue was an administrative determination and that "the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations." App., *infra*, 50a (emphasis added). Nevertheless, the court held that Haverford's claims against petitioner were not preempted under Section 514(a) of ERISA. App., *infra*, 54a. According to the Superior Court, "[c]onsiderations of cost containment of the type which drive the decision making process in HMOs" are not encompassed within the preemptive ambit of Section 514(a). App., *infra*, 50a.

3. In its first consideration of this case ("*Pappas I*"), the Supreme Court of Pennsylvania, although disagreeing with the reasoning of the Superior Court, affirmed its decision that Haverford's claims against petitioner were not preempted. App., *infra*, 31a. The court acknowledged that this Court gave a "deliberately expansive" interpretation to the preemption provision in Section 514(a) of ERISA in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983); and *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985). App., *infra*, 35a. Expressly refusing to follow those decisions, however, the court asserted that they were overruled *sub silentio* by *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). App., *infra*, 35a-39a.

In a sweeping pronouncement not confined to the facts of this case, the Pennsylvania Supreme Court stated in *Pappas I* that, "[b]ased upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App., *infra*, 39a. The court did not draw any distinction between negligence claims arising from an HMO's administration of plan benefits and negligence claims based on an HMO's purported vicarious liability for providers' malpractice or direct liability for its own exercise of medical judgment. Instead, the court's broad holding in *Pappas I* — which it reaffirmed in *Pappas II*, see App., *infra*, 2a, 14a — appears to preclude an HMO that has been sued for negligence from invoking the preemption provision of Section 514(a) under any set of circumstances.

4. On October 4, 1999, this Court invited the Solicitor General to file a brief expressing the views of the United States. 528 U.S. 804. The United States strongly disagreed with the broad holding of *Pappas I*, noting that *Travelers* reaffirmed, rather than questioned, the relevant holding of *Pilot Life*.

98-1836 U.S. Br. 16. The government also went further and considered whether a narrower rationale could be substituted for that indefensible broad holding. "When an HMO acts as a medical service provider, a number of courts have held — and we agree — that the HMO is subject to suit under state law for negligence in performing its medical duties." 98-1836 U.S. Br. 10. "On the other hand, when an HMO makes benefit determinations in its role as a plan administrator, most courts have held — and we agree — that ERISA preempts any state-law challenges to those decisions." *Ibid.* Despite a record that did not disclose any exercise of medical judgment and briefing that did not hint at any claim of such an exercise, the United States expressly considered, in the abstract, the possibility of the exercise of some medical judgment in the course of making a benefit eligibility determination. According to the government:

> As both the case law and the regulations show, such benefit determinations will often involve a significant component of medical judgment, and may have tragic medical consequences. But, so long as the judgment is an adjunct to a plan coverage decision, rather than a judgment made primarily in the course of diagnosis or treatment, it is a "benefit determination nonetheless."

Id. at 11 (quoting *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)).

The application of those abstract principles to the record in this case led to the unequivocal conclusion that "[r]espondents' common-law negligence claim is therefore preempted." 98-1836 U.S. Br. 14. As the government summarized (*id.* at 7):

> [I]t appears that petitioner denied Mr. Pappas a benefit he was entitled to receive under the terms of his plan — emergency care at a hospital outside the HMO network — and that respondents seek to hold petitioner liable for its negligence in making that erroneous benefit determination. When viewed in that light, respondents' claims are pre-empted by ERISA because they relate to plan adminis-

> tration and would provide an independent enforcement mechanism as an alternative to ERISA's limited remedies. As a result, the Pennsylvania Supreme Court decision is both incorrect in this case and overbroad as a general matter under existing law.

The United States rested its conclusions not only on the "relate to" language of Section 514(a), but also on the "field preemption" effect of ERISA Section 502(a), 29 U.S.C. § 1132(a), as construed in *Pilot Life*, 481 U.S. at 52. 98-1836 U.S. Br. 15-16.

The United States suggested that the Court hold the petition pending its decision in *Pegram* v. *Herdrich*, No. 98-1949, or, alternatively, grant plenary review because of "the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here." 98-1836 U.S. Br. 6.

5. After this Court decided *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), it granted the petition for certiorari in *Pappas I*, vacated the judgment, and remanded the case for further consideration. 530 U.S. 1241. Despite having called *Pappas I* both overbroad and wrong in its brief before this Court, the government filed a brief on remand before the Pennsylvania Supreme Court saying that its views "have changed in light of *Pegram*." U.S. Remand Br. 2. *Pegram*, according to the government, had "rejected the government's understanding * * * that an HMO's coverage decision is plan administration that is subject to ERISA's fiduciary standards even when it involves medical judgment about how to treat a patient." U.S. Remand Br. 11. In other words, the government was now taking the position — contrary to the position it took before this Court — that a coverage decision that included medical judgments was not necessarily "plan administration," but rather a "mixed treatment and eligibility" decision that would not be preempted. *Id.* at 12. Backing away from its earlier observation that there was *no* evidence in the record that petitioner made any medical decisions, the government now contended — without citing to the record — that petitioner's "transfer decision *may have*

involved some exercise of medical judgment." *Id.* at 16 (emphasis added). It therefore suggested that the Pennsylvania Supreme Court vacate the grant of summary judgment and remand to the Court of Common Pleas.

On remand ("*Pappas II*"), the Supreme Court of Pennsylvania, by a divided vote, held again that the claims against petitioner were not preempted. The majority rested its decision on two grounds. First, the majority "adhere[d] to [its] original opinion and order" and "confirm[ed] [its] original disposition." App., *infra*, 2a, 14a. Because, the majority held, its "analysis of ERISA preemption in *Pappas I* was founded on [Section 514(a) of ERISA] and the Supreme Court's most recent teaching on the matter," the analysis in *Pappas I* "continues to apply," App., *infra*, 14a n.7 — and thus "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," App., *infra*, 39a, and are therefore not preempted.

The majority also asserted that *Pegram* supports the same result. Although *Pegram* concerned fiduciary status under ERISA, and not the scope of ERISA preemption, the majority stated that *Pegram* set forth "two guiding principles." App., *infra*, 8a. First, "HMO physicians" act like both "plan administrators" and as "health care providers." Second, they may make "three types of decisions": "pure eligibility decisions," "treatment decisions," and "mixed eligibility and treatment decisions." Quoting *Pegram*, the majority stated (App., *infra*, 8a (citations omitted)):

> "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment," such as "whether a plan covers an undisputed case of appendicitis." "'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" "Mixed eligibility and treatment decisions" are just what their name implies — decisions in which coverage and medical judgment are intertwined.

Under *Pegram*, the majority held, "an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice * * * [that] is not preempted by ERISA." App., *infra*, 11a. The majority ignored the contrary decision in *Corporate Health Ins., Inc.* v. *Texas Department of Ins.*, in which the Fifth Circuit held that "[w]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 220 F.3d 641, 643 (5th Cir.), denying rehearing to 215 F.3d 526 (5th Cir. 2000), petition for cert. pending, No. 00-665. The majority also ignored the contrary decision in *Pryzbowski* v. *U.S. Healthcare, Inc.*, in which the Third Circuit held that ERISA § 502(a), 29 U.S.C. § 1132(a), did completely preempt a state-law claim that an HMO had negligently delayed approving a particular form of treatment — claims that like the ones in this case challenged "the policy adopted by [HMOs] requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists." 245 F.3d 266, 273 (3d Cir. 2001).[2]

The majority paid no heed, either, to the essential differences between the type of HMO involved in *Pegram*, in which the doctors who treated the patients were also owners/employees of the HMO, and HMO Pa., which contracts with independent doctors in private practice to provide all medical diagnosis and treatment. Finally, without citing the record — and contrary to what had been conceded throughout this litigation — the majority held that the "undisputed facts" established that petitioner's decision not to approve transfer to an out-of-network hospital was one of "mixed eligibility and treatment." App., *infra*, 12a-13a.[3] The claims therefore survived.

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[2] "Where a claim is preempted under § 502(a) it is necessarily preempted under § 514(a)." *Rice* v. *Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995). Respondents have previously conceded this point. 98-1836 Br. in Opp. 8.

[3] In so holding, the majority asserted that Medical Director Leibowitz, who made the decision not to approve benefits for a non-participating hospi-

Justice Saylor dissented. Citing both *Corporate Health Ins.* and *Pryzbowski*, he warned that "there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined" — and, in particular, that "other courts have been more circumspect" in holding that state claims are not preempted. App., *infra*, 16a. Justice Saylor read *Pegram* to "give[] cause for the exercise of a degree of caution" on courts' parts in "defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence." App., *infra*, 17a. In particular, Justice Saylor wrote, contrary to the majority's reading *Pegram* manifested this Court's "disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business." *Id.* at 20a. Justice Saylor then echoed the Third Circuit's comments in *Pryzbowski*: "A holding that Pryzbowski's claims against U.S. Healthcare" — claims indistinguishable in relevant part from the ones in this case — "are not completely preempted would open the door for legal challenges to core

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tal, was exercising "clinical judgment" (App., *infra*, 13a). Even if that statement had support in the record, it hardly would resolve the question whether the HMO's decision remained a "benefit determination" squarely governed by *Pilot Life*. Rather, as the United States correctly observed in 1999, a non-treating physician's determination with regard to benefit eligibility unquestionably constitutes an interpretation of the ERISA-governed plan, even if clinical judgment is involved. See 98-1836 U.S. Br. 11. But in any event the Pennsylvania court made up the "fact" of the exercise of "clinical judgment" out of thin air. Nothing in the record supports any suggestion that Medical Director Leibowitz was doing anything other than administering the plan and making a standard benefit eligibility determination. Indeed, the majority's newly minted suggestion in *Pappas II* that medical judgments were involved was contrary to the court's position in *Pappas I*, as the Solicitor General noted. 98-1836 U.S. Br. 12. Rather, "the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, made a *benefit determination*," *ibid.* (emphasis added), and not a medical decision. See also App., *infra*, 50a ("the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations") (emphasis added).

managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." Those challenges, however, were precisely the ones "eschewed in *Pegram*." App., *infra*, 20a n.6 (quoting *Pryzbowski*, 245 F.3d at 274-275).

REASONS FOR GRANTING THE PETITION

A. The Decision Below Conflicts With This Court's Decisions Construing Sections 502(a) And 514(a) Of ERISA

The third-party complaint by Haverford against petitioner challenges a straightforward and commonplace ERISA plan benefit eligibility determination: coverage would be provided to Mr. Pappas if he was transferred to any of three hospitals that had contracted with petitioner to provide hospital services to plan members, but would not be provided if he was transferred to Jefferson, which had no such contractual relationship with petitioner. Because Haverford's negligence claim against petitioner arises from and directly relates to the administration of benefits under the ERISA-governed health plan, and provides an alternative enforcement mechanism to ERISA, it falls squarely within the preemptive scope of Sections 502(a) and 514(a) of ERISA.

As the United States recognized in its *amicus* brief in *Pappas I*, the Pennsylvania Supreme Court's decision directly conflicts with this Court's decision in *Pilot Life*.[4] In *Pilot Life*, plaintiff had alleged that an insurance company engaged in the processing and review of claims for benefits under an employee benefit plan had acted tortiously when it terminated his disability benefits. Relying on *Metropolitan Life* and *Shaw*, this Court emphasized the "expansive sweep of the pre-emption clause" in Section 514(a) of ERISA. *Pilot Life*, 481 U.S. at 47. The Court noted that the legislative history of ERISA reflects

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[4] 98-1836 U.S. Br. 6 ("the blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48 (1987)").

"both the breadth and importance of the pre-emption provisions." *Id.* at 46. The Court held that "[t]he common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)." *Id.* at 48. The Court further held that "varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." *Id.* at 52.

The Pennsylvania Supreme Court's decision also conflicts with this Court's decisions in *Metropolitan Life* and *Shaw*. In both of those cases, this Court held that ERISA preempts state laws that require an ERISA-governed plan to provide certain types of coverage, because such a requirement "bears indirectly but substantially on all insured benefit plans." *Metropolitan Life*, 471 U.S. at 739. The Pennsylvania Supreme Court's ruling subjects petitioner and other health maintenance organizations to tort liability for failing to authorize a member's treatment at a non-participating hospital. In essence, the decision imposes a substantive coverage requirement on ERISA-governed health plans: either permit a member to be admitted to whatever hospital the treating physician selects — regardless of whether that hospital participates in the health maintenance organization's network — or face liability in tort for damages. Such a result cannot be reconciled with *Metropolitan Life* and *Shaw*. Moreover, it would wreak havoc on the federal and state HMO laws requiring plans to establish networks of participating providers. See 42 U.S.C. § 300e; 28 Pa. Code § 9.75.

The Pennsylvania Supreme Court tacitly acknowledged in *Pappas I* that the third-party complaint against petitioner would be preempted under *Pilot Life*, *Shaw*, and *Metropolitan Life*, but it expressly declined to follow those decisions, characterizing them as "superannuated." App., *infra*, 37a. Instead, it took the view that this Court "noticeably changed tack" in *Travelers* by adopting a "new position on ERISA preemption," and it further opined that "*Travelers* and its progeny [*Dillingham* and

DeBuono] have thrown the expansive holdings of those earlier cases into question." App., *infra*, 35a, 37a, 38a. The Pennsylvania Supreme Court relied very heavily in *Pappas I* on the concurring opinion in *Dillingham* by Justice Scalia (joined by Justice Ginsburg), and it asserted that Justice Scalia had "reproached the Court for not forthrightly acknowledging that the holdings of these older cases 'have in effect been abandoned.'" App., *infra*, 37a. However, the Pennsylvania Supreme Court truncated its quotation of Justice Scalia's comment, deleting the earlier part of his sentence in which he noted that the Court's opinion in *Dillingham* "does obeisance to all our prior cases." 519 U.S. at 335. Justice Scalia also stated in his concurring opinion in *Dillingham* that the majority opinion "is a fair description of our prior case law, and a fair application of the more recent of that case law" (*ibid.*), thereby acknowledging that *Pilot Life* remained good law.

Similarly, contrary to the Pennsylvania Supreme Court's mistaken belief, this Court's decision in *Travelers* did not overrule *Pilot Life*, *Shaw*, or *Metropolitan Life*, either expressly or by implication. To the contrary, *Travelers* concludes by expressing "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. The continuing vitality of *Pilot Life* and *Metropolitan Life* was most recently reaffirmed by this Court's decision *in UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999).

In addition to *Travelers*, the Pennsylvania Supreme Court relied in *Pappas I* on *DeBuono* v. *NYSA-ILA Medical & Clinical Serv. Fund*, 520 U.S. 806 (1997), in support of its contention that this Court's earlier decisions in *Pilot Life*, *Shaw*, and *Metropolitan Life* had been tacitly overruled. However, in *DeBuono*, this Court said just the opposite: it emphasized that these cases were not overruled, noting that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' * * * ERISA

benefit plans." *Id.* at 813. Here, too, it is not necessary to rely on an expansive interpretation of "relate to" in order to find preemption, because the negligence claim at issue arises directly from the petitioner's administration of benefits under the plan. Allegations that petitioner should have pre-approved Mr. Pappas's admission at a non-participating hospital and that it delayed unduly in advising the treating physician as to the participating hospitals to which Mr. Pappas could be transferred have a clear and direct "connection with or reference to" Mr. Pappas's benefit plan, and thus are preempted.

Travelers involved a state law having only a peripheral connection to ERISA benefit plans; significantly, the Court contrasted the statute before it with earlier cases where "ERISA pre-empted state laws that mandated employee benefit structures or their administration." 514 U.S. at 658. Here, subjecting petitioner to potential liability in tort on account of its refusal to pre-authorize a subscriber's admission to a non-participating hospital is tantamount to "mandat[ing] employee benefit structures or their administration." This is certainly true when an administrator makes a pure eligibility decision, as petitioner did here, but it is no less true when an administrator makes a "mixed eligibility and treatment" decision: in both cases, tort liability "would have a marked effect on plan administration," *UNUM Life Ins.*, 526 U.S. at 378-379. Given that effect, such a state-law claim would clearly "relate to" an ERISA plan under Section 514(a) and would thus be preempted.

Nor was the Pennsylvania Supreme Court free to disregard *Pilot Life*, *Shaw*, and *Metropolitan Life* simply because it thought them "superannuated." App., *infra*, 37a. This Court has admonished lower courts not to anticipate the overruling of precedent, stating that "[o]ur decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn* v. *United States*, 524 U.S. 236, 252-253 (1998); accord *Rodriguez de Quijas* v. *Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989) ("If a precedent of this Court has

direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower court] should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.").

The Pennsylvania Supreme Court's unprecedented holding in *Pappas I* — expressly reaffirmed in *Pappas II* — that any and all negligence actions against health maintenance organizations do not "relate to" an ERISA plan stands in direct conflict with this Court's decision in *Pilot Life*, where this Court held that Sections 502(a) and 514(a) preempt suits alleging improper processing of a claim for benefits. A cause of action predicated on a health maintenance organization's alleged negligence in administering benefits under an ERISA-governed plan plainly "relates to" the plan and provides an alternative enforcement mechanism not contemplated by ERISA itself, and is therefore preempted under Sections 502(a) and 514(a) of ERISA.

This Court's recent decision in *Pegram* does not suggest otherwise. To begin with, *Pegram* was not a preemption case at all, holding only that ERISA does not impose a fiduciary duty on HMO physicians for their mixed eligibility and treatment decisions. 530 U.S. at 237. Indeed, the Court nowhere even alluded to the meaning of the critical phrase "relate to" in Section 514(a) or to the scope of field preemption effected by Section 502(a). The Court did, however, specifically note that it did not have occasion "to discuss the interaction" of claims for denials of benefits "with state law causes of action." 530 U.S. at 229 n.9; see also Note, *What Is an Employee Benefit Plan? ERISA Preemption of "Any Willing Provider" Laws After* Pegram, 101 COLUM. L. REV. 1107, 1123 (2001) ("Of course, even after *Pegram*, the previous cases analyzing the meaning of 'relate to' remain good law.").

Moreover, in *Pegram* this Court eschewed legal challenges to practices like the "rationing" of care that "go[] to the very point of any HMO scheme." 530 U.S. at 221; see also *Pryzbowski*, 245 F.3d at 274-275. Subjecting petitioner to state tort law

liability for providing coverage at network hospitals rather than an out-of-network hospital would thus be contrary to — not consistent with — *Pegram*.

In fact, in his dissent in this case Justice Saylor noted that even on the majority's terms petitioner's decision would have survived, given the important difference between the types of HMOs involved here and in *Pegram* (App., *infra*, 17a n.3):

> [T]he decision made in *Pappas* was far closer on the continuum to the eligibility form than that which was at issue in *Pegram*, since, under U.S. Healthcare's modified IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in *Pegram*. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. *See generally Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 2001 WL 292997, 2001 U.S. App. LEXIS 4903 (3d Cir. Mar. 27, 2001) (holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

Indeed, this type of litigation is so clearly preempted by the exclusive remedies set forth in ERISA that many courts of appeals would permit removal of a suit of this nature on that ground alone. Perhaps for that reason, Mr. and Mrs. Pappas never brought suit against petitioner. It would be anomalous to permit third parties, such as respondent, effectively to circumvent the congressional scheme by the simple expedient of bringing a third-party complaint against petitioner.

B. The Decision Below Conflicts With Decisions By The Third Circuit And Numerous Other Courts Of Appeals Throughout The Country

Conspicuous by its absence from the decisions in *Pappas I* and *Pappas II* is the citation of any case from any court that supports either the Pennsylvania Supreme Court's astonishing assertion that all negligence claims against health maintenance organizations fall outside the preemptive scope of Section 514(a) or its alternative holding that all "mixed" decisions survive ERISA preemption in the wake of *Pegram*. Indeed, the Pennsylvania Supreme Court did not and could not cite any case in support, and none exists.

The Pennsylvania Supreme Court's affirmation in *Pappas II* of its ruling in *Pappas I* that all negligence claims against HMOs are not preempted conflicts with the Third Circuit's decisions in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, cert. denied, 516 U.S.1009 (1995), and *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266 (2001), creating a split between the state and federal courts in Pennsylvania on this issue. Resolution of this conflict is necessary to prevent forum shopping. See *Yee* v. *City of Escondido*, 503 U.S. 519, 538 (1992) (granting certiorari to resolve conflict between Ninth Circuit and California state courts, this Court noted that "[f]orum shopping is thus of particular concern"); *Baldwin* v. *Alabama*, 472 U.S. 372, 374 (1985) (granting certiorari to resolve conflict between Eleventh Circuit and Supreme Court of Alabama).

In *Dukes*, the Third Circuit held that ERISA preempts claims based on utilization review decisions and other plan benefit eligibility determinations, but does not preempt claims challenging the quality of care a subscriber receives. The Pennsylvania Supreme Court's declaration that all negligence claims against a health maintenance organization are outside the preemptive scope of Section 514(a), even if they relate to the administration of benefits under a plan, is in direct conflict with *Dukes*. See *Huss* v. *Green Spring Health Services, Inc.*, No. 98-6055, 1999 U.S. Dist. LEXIS 5101, *13 (E.D. Pa. April 16,

1999) (noting the "tension" between *Dukes* and the Pennsylvania Supreme Court's decision in this case and following *Dukes*). Remarkably, the Pennsylvania Supreme Court made no mention at all of *Dukes* in either *Pappas I* or *Pappas II*, simply ignoring the suggestion by Justice Nigro in his concurring opinion in *Pappas I* to adopt the rationale of the *Dukes* decision. App., *infra*, 41a-42a.[5]

The *Pappas II* majority likewise ignored *Pryzbowski* (in the face of Justice Saylor's discussion of *Pryzbowski* in his dissent). In that case, construing Section 502(a), the Third Circuit held that ERISA completely preempted negligence and other state law claims arising from delay in approving requested services because such delay was "conduct falling squarely within administrative function." 245 F.3d at 274. As Judge Sloviter's opinion for the unanimous court explained: "A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*." *Id.* at 274-275. By comparison, in *Pappas II*, the Pennsylvania Supreme Court held that claims based on delay in approving treatment are not preempted by ERISA and characterized its own ruling in *Pappas I* as "consistent with the Supreme Court's decision in *Pegram*." App., *infra*, 13a-14a. As Justice Saylor observed in his dissenting opinion in *Pappas II*, there is a direct conflict between *Pappas II* and *Pryzbowski*. App., *infra*, 18a n.3.

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[5] In our prior certiorari petition (98-1836 Pet. 14 n.4), we explained that Justice Nigro misread *Dukes*. Furthermore, *Dukes* itself draws a tenuous and manipulable line between "quality of care" and "quantity of care" that may not ultimately represent a faithful interpretation of ERISA. But what matters for present purposes is that the Supreme Court of Pennsylvania has consistently ignored *Dukes* and drawn a line completely inconsistent with the analysis in *Dukes*, as well as inconsistent with the contrary post-*Pegram* decision on indistinguishable facts in *Pryzbowski*.

The Pennsylvania Supreme Court did acknowledge in *Pappas I* (though not in *Pappas II*) that a number of federal appellate decisions hold to be preempted or completely preempted negligence claims against health maintenance organizations that, like the claim asserted here against petitioner, arise from the administration and processing of claims for benefits under an ERISA-governed plan. App., *infra*, 38a n.5. However, just as it refused to follow this Court's pre-*Travelers* decisions because it believed they were no longer good law, so too did it disregard the many relevant court of appeals decisions, declaring that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." *Ibid.*

In fact, after *Travelers*, the federal courts of appeals have continued to hold — uniformly — that, under *Pilot Life*, Sections 502(a) and 514(a) preempt claims arising from the administration of benefits under an ERISA plan, such as refusals to authorize coverage for a particular type of treatment or refusals to authorize coverage at a particular hospital. See *Pryzbowski*, 245 F.3d at 274 (claims for delay in approving surgery are preempted by ERISA because they involve "conduct falling squarely within administrative function"); *Thompson* v. *Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (ERISA preempted claims arising from refusal to authorize high dose chemotherapy or bone marrow transplant); *Hull* v. *Fallon*, 188 F.3d 939, 943 (8th Cir. 1999) (claims involving denial of thallium stress test "relate to the administration of benefits" and are preempted by ERISA), cert. denied, 528 U.S. 1189 (2000); *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999) (ERISA preempted claims for denial of precertification for treatment at one hospital and precertification for admission to a different hospital); *Bast* v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (claims arising from delay in authorizing bone marrow transplant were preempted); *Parrino* v. *FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.) (claims arising out of delay in approving proton beam cancer therapy were preempted), cert. denied, 525 U.S. 1001 (1998); *Englehardt* v.

Paul Revere Life Ins. Co., 139 F.3d 1346, 1353 (11th Cir. 1998) (ERISA preempted tort challenge to plan's decision to deny plaintiff's claim for benefits); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant), cert. denied, 523 U.S. 1072 (1998); *Painter* v. *Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997) (ERISA preempted claim stemming from refusal to authorize coverage for high-dose chemotherapy cancer treatment), cert. denied, 523 U.S. 1074 (1998); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (ERISA preemption applies to "allegations of negligence based on a failure to treat where the plan denied benefits for the proposed treatment"); *Cannon* v. *Group Health Serv.*, 77 F.3d 1270, 1273 (10th Cir.) (ERISA preempted suit arising from delay in authorizing bone marrow transplant), cert. denied, 519 U.S. 816 (1996).[6]

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[6] The Pennsylvania Supreme Court's decision also conflicts with a number of pre-*Travelers* court of appeals decisions that, relying on *Pilot Life*, had held that ERISA preempted claims based on the alleged improper administration of benefits under a plan. *Tolton* v. *American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (ERISA preempted claims arising from refusal to authorize psychiatric treatment under the plan; "American Biodyne and its employees were determining what benefits were available to Tolton under the plan."); *Spain* v. *Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (ERISA preempted claim based on delay in authorizing coverage for bone marrow transplant; plaintiff's claim "seeks damages for the negligent administration of benefit claims"), cert. denied, 511 U.S. 1052 (1994); *Kuhl* v. *Lincoln National Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (plan refused to certify payment for heart surgery at a hospital outside the plan's service area; "the decision not to precertify payment relates directly to Lincoln National's administration of benefits"), cert. denied, 510 U.S. 1045 (1994); *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.) (plan authorized home nursing care for pregnant woman rather than hospitalization; "the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination"), cert. denied, 506 U.S. 1033 (1992); *Settles* v. *Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (claim based on allegedly unlawful termination of coverage was preempted; "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan").

Not only is there a direct conflict between the broad holding that *no* "negligence claims against a health maintenance organization" can "'relate to' an ERISA plan" under Section 514(a) and the federal courts of appeals cases cited above, there is an equally direct conflict between the federal courts of appeals and the alternative holding in *Pappas II* that "mixed eligibility and treatment" decisions can, in light of *Pegram*, be challenged under state law. In *Corporate Health Ins.* — which the Pennsylvania Supreme Court failed to mention — the Fifth Circuit stated so expressly: "[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption as long as it is based on a mixed question of eligibility and treatment." 220 F.3d at 643. Here, the Pennsylvania Supreme Court read *Pegram* exactly as the Fifth Circuit did not. And the Pennsylvania Supreme Court's decision conflicts as well with the Third Circuit's decision in *Pryzbowski*.

There, a patient sued under state law for supposed negligence in an HMO's delay in authorizing particular treatment. Borrowing the same terminology from *Pegram* as did the Pennsylvania Supreme Court, the Third Circuit held that such a claim was one "to enforce [a person's] rights under the terms of the plan" and thus completely preempted under ERISA Section 502(a) and, *a fortiori*, "relate[d] to" a plan under Section 514(a). See 245 F.3d at 274-275 (preemption of delay claims consistent with *Pegram*'s rejection of "legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)").[7]

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[7] See also *Calad* v. *Cigna Healthcare of Texas, Inc.*, No. CIV. 300-CV-2693-H, 2001 WL 705776 (N.D. Tex. June 21, 2001) (noting that *Pegram* "was not a preemption case" and holding that "claims arising from a delay or denial of benefits are ERISA-preempted"); *Roark* v. *Humana, Inc.*, No. CIV. A. 3:00-CV-2368D, 2001 WL 585874, *4 (N.D.Tex. May 25, 2001) (holding *Pegram* inapplicable to claim for delay or denial of approval for skilled nursing home care because the claim "is about administration of benefits, not quality of medical treatment"); *Rubin-Schneiderman* v. *Merit Behavioral Care Corp.*, 25 EMPL. BEN. CAS. 2542 (CCH) ¶ 23971U (S.D.N.Y. Apr. 10, 2001) (relying on *Pryzbowski* for holding that

Critical to the Third Circuit's analysis under *Pegram* was its understanding that this Court determined that Congress wanted to *reject* broad-based state-law attacks on the business justifications for HMOs. A claim such as the one in *Pryzbowski* — and the one here — that an HMO had wrongly delayed or denied benefits "would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." 245 F.3d at 274-275. Such challenges are precisely the kind that Congress decided to preempt. See *id.* at 275 (noting that in *Pegram* the Court "reject[ed] claims attacking financial incentives behind HMO structure, in light of [the] congressional policy of promoting HMOs").

Petitioner's decision that Mr. Pappas would be afforded coverage if he was transferred to any of the three designated participating hospitals, but not if he was transferred to a non-participating hospital (Jefferson), was a prototypical determination concerning the eligibility of Mr. Pappas to benefits and under *Pilot Life* should have been held preempted. And even if petitioner's decision had been "mixed" (which it was not), involving both an eligibility determination and questions of treatment, it should also have been preempted. In holding that either *no* negligence claims are preempted, or that at least negligence claims challenging mixed decisions are not preempted, the Pennsylvania Supreme Court has created a conflict with decisions of other courts. The latter holding not only reflects an erroneous attribution of talismanic significance, for preemption purposes, to the "mixed" label, but also reflects a legally (see

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"determinations of whether requested treatment is covered under a policy relate to plan administration" and challenges to them are therefore preempted); *Schusteric* v. *United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2001 WL 1263581, *2 (N.D. Ill. Sept. 5, 2000) ("*Pegram*'s discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA § 1109 says nothing about whether a negligence claim of the type alleged in this case [*i.e.*, for delay in approving physical therapy] is completely preempted by § 502(a).")

98-1936 U.S. Br. 11) and factually (see note 3, *supra*) erroneous classification of this case as one involving a "mixed" determination.

The third-party complaint brought by Haverford not only complains of petitioner's refusal to pre-authorize coverage for Mr. Pappas at Jefferson, but also alleges that petitioner contributed to the delay in transferring Mr. Pappas from Haverford to a more suitable hospital. App., *infra*, 6a & n.2. The Pennsylvania Supreme Court stated in *Pappas I* that "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care" and are not preempted. App., *infra*, 39a. However, that ruling conflicts with six of the federal appellate decisions cited above, where the courts of appeals held that, under *Pilot Life*, ERISA preempts claims based on undue delays by plan administrators in approving particular treatments or benefits. *Pryzbowski*, 245 F.3d at 273 ("Underlying these allegations of delay is the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists. These activities fall within the realm of the administration of benefits."); *Bast* v. *Prudential Ins. Co.*, 150 F.3d 1003; *Parrino* v. *FHP, Inc.*, 146 F.3d 699; *Cannon* v. *Group Health Service*, 77 F.3d 1270; *Spain* v. *Aetna Life Ins.*, 11 F.3d 129; *Kuhl* v. *Lincoln Nat. Health Plan*, 999 F.2d 298.

The decision in *Pappas I*, as re-affirmed and expounded on in *Pappas II*, stands alone in its wholesale evisceration of the preemption defense that other courts have upheld for ERISA plan benefit eligibility determinations. As the United States observed in its amicus curiae brief in *Pappas I*, the Pennsylvania Supreme Court's decision "conflicts with a long line of federal court of appeals decisions, both before and after *Travelers*, holding that ERISA preempts state-law challenges to decisions by HMOs, insurers, utilization review organizations, and

other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals." 98-1836 U.S. Br. 17. The conflict between the Pennsylvania Supreme Court's decision and all of the federal courts of appeals decisions referred to above is stark, and that conflict can be resolved only by this Court.

C. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In Lower Courts

Although this Court has rendered decisions in 18 cases addressing the boundaries of ERISA's preemptive reach,[8] it has not yet addressed ERISA preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations.

Lacking guidance from this Court, the federal and state courts have struggled mightily with the interplay of Sections 502(a) and 514(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. The courts have employed differing analytical frameworks, have reached widely divergent conclusions, and have created tremendous confusion, uncertainty, and unpredictability in a vitally important area of the law that affects the tens of millions of people who

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[8] The Court itself identified 16 cases in *DeBuono*, 520 U.S. at 808 n.1. Since then, the Court has decided *UNUM Life Ins.*, 526 U.S. 358, and *Egelhoff* v. *Egelhoff ex rel. Breiner*, 121 S. Ct. 1322 (2001). Contrary to the Pennsylvania Supreme Court's apparent belief that this Court no longer regards ERISA as having any meaningful preemptive scope, *Egelhoff* (in full) and *UNUM* (in part, 526 U.S. at 377-379) resulted in determinations that state law was preempted by ERISA.

participate in managed health care. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit plans obtained through a qualified employer are within the scope of ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO, or a self-funded plan.

In its amicus curiae brief in *Pappas I*, the government stated (98-1836 U.S. Br. 18):

> We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided. * * * The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.[9]

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[9] The government's December 1999 statement in this case that the issues are sufficiently important to deserve review in this Court notwithstanding the possibility of new legislation contrasts with its June 2001 statement that somewhat related issues — involving not preemption of state tort actions, but rather preemption of state statutes mandating external independent review of managed care organizations' medical necessity decisions — should not be reviewed because essentially the same issues are pending before Congress. Brief for the United States as Amicus Curiae (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021. This Court's June 29 grant of certiorari in *Rush Prudential* suggests that neither the circuit split involved in that case nor the related but different split involved in this case should go unresolved just because of the possibility of legislation. In any event, as of the date of the filing of this petition, the prospects for new legislation in the near future are

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework * * * through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers * * *." B. Richardson, *Health Care: ERISA Preemption and HMO Liability — A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677, 679 (1996). The "myriad of confusion" that now exists in the federal and state courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

"With no specific guidance from the Supreme Court in this area, lower courts have floundered and strained," and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow & L. Greenlees, *ERISA Pre-emption — A Law in Search of a Doctrine*, HEALTH LAW DIGEST, March 1999, at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption issues. Second, the courts will continue to struggle by drawing distinctions — some meaningful, some not — in the hope of reaching results that are both equitable and in accord

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doubtful. See *White House Tries to Influence Debate on Patients' Bill of Rights Legislation*, 70 U.S.L.W. 2042 (July 17, 2001) (although S. 1052 has passed the Senate, President Bush has threatened to veto it "on grounds that it provides for far too broad an expansion of the scope for lawsuits," and competing bills are pending in the House, making the entire outcome as well as its intermediate steps quite unclear); Amy Goldstein & Juliet Eilperin, *Bush Lobbies Hill On Patient Rights*, WASH. POST, July 27, 2001, at A1 (reflecting postponement of House vote and uncertainty of timing of future House consideration).

> with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. Accord K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 304 (1996) ("the outcomes on the issue of ERISA preemption [of tort claims against HMOs] have been inconsistent — indeed, the situation might be characterized as one of utter confusion on the issue"); K. Bartholomew, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131, 1133 (1999) (noting "doctrinal confusion and 'chaos' in the lower courts," with the result that "[l]ittle judicial guidance * * * currently exists for interpreting ERISA's poorly constructed preemption clause"); P. Jacobson & S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1032 (1998) (decisions considering ERISA preemption of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity — exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1051 (1996) ("these various approaches have created incongruity and analytical inconsistency among courts").

Pegram has hardly solved the problem. Although there are those who (perhaps opportunistically) purport to find hidden in *Pegram* clear guidance about preemption — even though preemption was *not* at issue in *Pegram* — others correctly observe that, "[a]fter *Pegram*, the limits of ERISA preemption are as murky as ever, with the Supreme Court's opinion casting as

much shadow as light on an issue that has long cried out for resolution." A. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL. MED. 55, 56 (2001); see also *ibid.* ("judicial clarification * * * [is] still sorely needed"); *id.* at 75 ("the *Pegram* decision gives mixed and conflicting signals"). The conflict between the decision below and *Pryzbowski* reflects the inevitability of continued discord in the lower courts, post-*Pegram*, unless this Court steps in. See also Brief for the United States as Amicus Curiae 17-19 & nn.5-6 (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021 (recognizing conflict between decision below and *Pryzbowski*; framing the question as "what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis"; observing that "[t]he answer to that question could be of very broad significance"; and repeating that "the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications").[10]

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[10] There is a sufficient overlap between the issues on which the Court has granted certiorari in *Rush Prudential* and the issues raised by this petition that this case should at least be held pending the disposition of *Rush Prudential*, yet the cases also are sufficiently different that an outright grant rather than a hold would be better. On the one hand, both cases pose the question whether *Pegram*, which was a fiduciary duty case and not a preemption case, changes preemption analysis at all. As the quotations in the text show, the United States — despite the brief it filed in the Pennsylvania Supreme Court — now seems to be signaling this Court that it has grave doubts that *Pegram* has "any" "effect * * * on ERISA preemption analysis." 00-665 U.S. Br. 18. On the other hand, the existence of the necessary "relat[ion] to" an ERISA plan was accepted by the Court below in *Rush Prudential*, whereas the existence of such a relation is what is at issue in this case. See *Moran* v. *Rush Prudential HMO, Inc.*, 230 F.3d 959, 968 (7th Cir. 2000). *Rush Prudential* seems likely to turn more on the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A), than on the construction of 29 U.S.C. §§ 1132(a) and 1144(a) at issue here. Compare 230 F.3d at 969-973 (construing insurance savings clause to have dispositive effect in that case), with 98-1836 U.S. Br. 14 n.10 ("this case [*Pappas*] does not involve ERISA's insurance savings clause or its construction in *Pilot Life*").

ERISA preemption in the context of negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal and state courts until this Court finally steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the lower courts in grappling with this difficult issue. Indeed, legal commentators have described the decision in *Pappas II* as one whose "implications * * * are 'enormous'"[11] and as potentially "the case everyone is waiting for" to secure this Court's review.[12]

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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[11] *On Remand From U.S. Supreme Court, Pennsylvania Finds No ERISA Bar To Suit*, 10 HEALTH LAW REP. (BNA) 592, 593 (Apr. 12, 2001).

[12] M. Morrissey, *An HMO Tale of Rashomon*, NAT'L L.J., June 18, 2001, at A1, A17.

APPENDIX A

Supreme Court of Pennsylvania.

In re Basil PAPPAS and Theodora Pappas, H/W, Plaintiffs,
v.
David S. ASBEL, D.O., Defendant.
Pennsylvania Hospital Insurance Co. (PHICO) and The Commonwealth of
Pennsylvania Medical Professional Liability Catastrophe Loss Fund (Cat Fund),
Defendants/Appellees.
United States Healthcare System of Pennsylvania, Inc.,
Additional
Defendant/Appellant.

Submitted Aug. 29, 2000.
Decided April 3, 2001.

Before: FLAHERTY, ZAPPALA, CAPPY, CASTILLE, NIGRO, NEWMAN and SAYLOR, Justices

OPINION

CAPPY, Justice.

Based on the principles the United States Supreme Court articulated in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), we issued an opinion in the instant case on December 23, 1998, holding that the state law medical negligence claims asserted against third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.

1001 *et seq. Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (1998) ("*Pappas I* "). Accordingly, we affirmed the Superior Court's order, reversing the trial court's entry of summary judgment in U.S. Healthcare's favor. *Id.* at 894.[1] On June 19, 2000, the Supreme Court entered an order granting certiorari in *Pappas I*, vacating the judgment of this court, and remanding the case for our further consideration in light of *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). For all the reasons that follow, we adhere to our original opinion and order.

The facts and procedural history, as set forth in *Pappas I*, bear repeating.

> At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.
>
> Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a

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[1] Our reasons for finding against ERISA preemption differed from those relied upon by the Superior Court. The Superior Court was of the view that considerations of cost containment that drive HMO decisions did not exist when Congress enacted ERISA. *Pappas v. Asbel*, 450 Pa.Super. 162, 675 A.2d 711, 716 (1996). The Superior Court concluded, therefore, that Congress could not have intended to preempt that which it did not know would come into existence. *Id.* Inasmuch as one year preceding the enactment of the statute, Congress passed the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, we could not agree that HMOs were unforeseen by Congress when it drafted ERISA. *Pappas I*, 724 A.2d at 893 n. 6.

neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further treatment.

At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:[05]p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however, determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

[1] It is uncontested that U.S. Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

Pappas I, 724 A.2d at 889-91.

Our legal analysis in *Pappas I* began with a review of the basic principles of preemption law. We noted that the

Supremacy Clause of the United States Constitution, U.S. Const., art. VI, cl. 2, gives the United States Congress the power to preempt state law, and observed that in determining whether state law is preempted by federal law, we were to assume that the historic powers of the states are not superceded [*sic*] unless preemption is the "clear and manifest purpose" of Congress. *Id.* at 891 (*quoting Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1992)) (citations omitted).

Turning to the express preemption section of ERISA, which states that "the provisions of this subchapter ... shall supercede [*sic*] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....", 29 U.S.C. § 1144(a), we recognized that in the 1980's and early 1990's, the Supreme Court had given ERISA preemption a notably expansive scope based on the plain language of this section. *Pappas I*, 724 A.2d at 891-92. With its 1995 decision in *Travelers*, however, we determined that the Court had signaled a change in course, instructing the courts to look to the objectives of ERISA, and not solely to the bare, "unhelpful" text of the statute, for guidance in deciding questions of preemption. *Id.* at 892, (*quoting Travelers*, 514 U.S. at 656, 115 S.Ct. 1671). We deemed it significant that the Court determined that the "basic thrust of the preemption provision ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans"; that it recognized fairly significant bounds on preemption when it stated that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability"; and that it cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 892 (*quoting Travelers*, 514 U.S. at 661, 115 S.Ct. 1671).

Applying *Travelers* and its progeny, *California Division of Labor Standards Enforcement v. Dillingham Construction NA., Inc.*, 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) and *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997), to the case *sub judice*, we determined that the negligence claims in plaintiffs' complaint, which Haverford incorporated by reference against U.S. Healthcare in its third party complaint, are not preempted. *Pappas I*, 724 A.2d at 894.[2] We found that they do not "relate to" an ERISA plan within the meaning of 29 U.S.C. § 1144(a), and that local negligence laws, like many laws of general applicability, are only remotely connected to ERISA plans. *Id.* at 893, 894. In view of the Supreme Court's determination that Congress did not intend to preempt state laws aimed at regulating health care, we held it would have been inappropriate to conclude that Haverford's claims, in which the issue of U.S. Healthcare's allegedly dilatory delivery of contractually-guaranteed medical benefits were intertwined with the question of safe medical care, are preempted by ERISA. *Id.* at 893.[3]

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[2] Haverford asserted the following allegations from plaintiffs' complaint against U.S. Healthcare:

24. The negligence of [Haverford] ... consisted of the following:

a. Failing to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. Delaying inordinately in transferring the patient, keeping him at [Haverford] during which time his spinal cord compression continued, with resulting permanent damage to the patient's spinal cord.

Complaint, para. 24.

[3] Justice Nigro filed a concurring opinion. In Justice Nigro's view,

We now turn, as instructed by the Supreme Court, to a reconsideration of our decision in *Pappas I* in light of *Pegram*. We start with a somewhat detailed rendition of *Pegram's* facts, as they are critical to our present task. The case arose out of a lawsuit brought by Cynthia Herdrich against her treating physician, Dr. Lori Pegram, and the health maintenance organization ("HMO") that Dr. Pegram and her partners owned and operated. The HMO had contracted with the company that employed Herdrich's husband to provide pre- paid medical services to its employees and their respective families. Dr. Pegram examined Herdrich for pain in the midline area of her groin, and discovered an inflamed mass in her abdomen. Dr. Pegram did not order an immediate ultrasound at the local hospital, but decided to wait some eight days for an ultrasound at a facility staffed by HMO physicians. Before the ultrasound could be performed, Herdrich's appendix ruptured, causing peritonitis.

Herdrich sued Dr. Pegram and the HMO in state court for medical malpractice, and later added two counts of state law fraud. Asserting that the fraud counts were preempted by ERISA, Pegram and the HMO removed the case to federal district court, and moved for summary judgment. The district court granted the defendants summary judgment on the first count, but granted Herdrich leave to amend the second. She did, alleging that the provision of medical services under the terms of the HMO, which rewarded its physician owners for limiting medical care, amounted to an inherent or anticipatory

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the facts demonstrated that "U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Pappas I*, 724 A.2d at 889. It can fairly be said that Justice Nigro's approach to the question of ERISA preemption in this case anticipated the Supreme Court's reasoning in *Pegram*.

breach of ERISA's fiduciary duties as set forth in 29 U.S.C. § 1109(a), to make decisions with the exclusive interest of plan participants in mind. The HMO moved to dismiss the ERISA count for failure to state a claim upon which relief could be granted. Finding that the HMO was not involved in the events at hand as an ERISA fiduciary, the district court sustained the motion. The Court of Appeals for the Seventh Circuit reversed.

The Supreme Court granted certiorari to determine whether treatment decisions made by an HMO, acting through its physicians, are fiduciary acts within the meaning of ERISA. The Court held that they are not. *Pegram*, 530 U.S. 211, 120 S.Ct. at 2146.

In the course of doing so, the Court set forth two guiding principles. First, HMO physicians occupy dual roles. They act like plan administrators when they determine, for example, whether a participant's condition is covered, and as health care providers, when they decide upon the medical treatment a participant will receive. *Id.* at 2153-54.

Second, HMO physicians make three types of decisions. "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment," *id.* at 2154, such as "whether a plan covers an undisputed case of appendicitis." *Id.* at 2155. " 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* at 2154. "Mixed eligibility and treatment decisions" are just what their name implies-decisions in which coverage and medical judgment are intertwined. *Id.* at 2154-55. In this regard, the Court explained:

> [A] great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether

> acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases.... In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment....

Id. at 2154.

To illustrate the wide array of decisions that are of the mixed type, the Court noted the decisions mentioned in Herdrich's complaint: "physician's conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental nature of a proposed course of treatment, the reasonableness of a certain treatment and the emergency character of a medical condition." *Id.* at 2155.

Turning to the case at hand, the Court found that the HMO, through Dr. Pegram, made a mixed decision, "decid[ing] (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat." *Id.* at 2154.

The Court then held that Congress did not intend that any HMO be treated as an ERISA fiduciary to the extent that it makes mixed eligibility and treatment decisions acting through its physicians. *Id.* at 2155.[4] Observing that under the common

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[4] The HMO in *Pegram* was owned by its physicians. U.S. Healthcare contracts with independent physicians to provide services. *Pegram*'s

law of trusts, which is the source of ERISA's fiduciary duties, fiduciary responsibility characteristically attaches to financial decisions about managing assets and property, the Court doubted that Congress would have ever thought of a mixed decision as fiduciary in nature. *Id.* at 2155-56. Because the defense of any HMO of a mixed decision would be that its physician acted for good medical reasons, the plausibility of which would require reference to traditional standards of reasonable medical practice in like circumstances, the Court was concerned that a decision to view a mixed decision as an act of ERISA fiduciary duty would "federalize malpractice litigation". *Id.* at 2157-58. Lastly, the Court touched upon (but declined to resolve) the "puzzling issue of preemption" that would be raised by the imposition of ERISA's fiduciary requirements upon an HMO physician making a pure treatment or mixed decision, in view of its holding in *Travelers*:

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the same subject of a state-law malpractice claim.... To be sure, [*Travelers*] throws some cold water in the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could

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result was based on the nature of the HMO's decision, not on the structure of the HMO making it. *Pegram*, 530 U.S. at 230-31, 120 S.Ct. at 2155. Further, the Supreme Court's holding was all-inclusive as to HMOs. *Id.* Thus, the difference in organization between the HMO in *Pegram* and U.S. Healthcare is not relevant to this analysis.

> struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors to a fiduciary malpractice claim....

Pegram, at 2158 (citations omitted).

While *Travelers* and *Pegram* deal with different aspects of ERISA, for our present purposes, they share common ground. *Travelers* instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. *Pegram* instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus, if Haverford's third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law, which is what Haverford asserted. Moreover, under *Travelers*, it is not preempted by ERISA.

It follows that we must now determine what the record on summary judgment reveals with regard to the nature of the U.S. Healthcare's decision. We view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre*, 532 Pa. 142, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead Industries Ass'n, Inc.*, 547 Pa. 224, 690 A.2d 169, 171 (1997). Our scope of review of a trial court's order granting or denying summary judgment is plenary, *O'Donoghue v. Laurel Savings Ass'n*, 556 Pa. 349, 728 A.2d 914, 916 (1999), and our standard of review is clear: the trial court's order will be reversed only where it is established that the court committed an error of law or abused its discretion. *Cochran v. GAF Corp.*, 542 Pa. 210, 666 A.2d 245, 248 (1995).

Having looked again at the record, there are facts that are not disputed, in addition to those set forth in *Pappas I*, that are important to our analysis. Dr. Dickter, the physician who first saw Pappas in the emergency room of Haverford on May 21, 1991, at about 11:00 a.m., received permission from Jefferson to admit Pappas to its spinal cord trauma center. Dr. Dickter chose Jefferson because it, unlike other hospitals, had designated space for spinal trauma cases and was able to determine immediately whether it was in a position to receive a new patient. When Dr. Dickter learned at 12:40 p.m. from ambulance personnel that Pappas' transfer to Jefferson was not HMO approved, he telephoned U.S. Healthcare at 12:50 p.m. and asked that it reconsider its decision. Dr. Dickter spoke to Elaine Norman, a U.S. Healthcare representative, and told her that Pappas' condition constituted a neurological emergency that needed immediate attention, and for which he had made arrangements with Jefferson. Ms. Norman advised Dr. Dickter that she was not authorized to take action one way or the other, but that she would consult with someone who was. At 1:05 p.m., Dr. Dickter spoke with Carol DeLark, another U.S. Healthcare representative. She told him that Dr. Liebowitz [*sic*], one of U.S. Healthcare's physicians who had the authority to decide such matters, reviewed Pappas' case; that the referral to Jefferson, a non-HMO hospital, continued to be denied; and that a referral to the facilities affiliated with Hahnemann, Temple University or MCP was approved. At about 3:30 p.m., through Dr. Dickter's efforts, Pappas was admitted to MCP.

Not surprisingly, U.S. Healthcare argues that its decision about Pappas' referral "constituted a quintessential 'coverage' determination".[5] We, however, disagree. In our view, the

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[5] A number of the statements U.S. Healthcare made when this appeal was originally heard do not reflect its present position that its decision was entirely devoid of medical judgment as to treatment. In its Reply Brief, for example, U.S. Healthcare stated that its "sole involvement in this matter was to answer a physician's question concerning what

undisputed facts in this case, and the inferences drawn from them, establish the sort of mixed eligibility and treatment decision that *Pegram* discussed.[6] Dr. Leibowitz, U.S. Healthcare's physician, reviewed Pappas' case, and rejected another medical doctor's opinion based on his clinical judgment that Pappas needed to be referred to Jefferson for treatment of a medical emergency. Instead of referring Pappas to Jefferson, a non-HMO hospital, as Dr. Dickter recommended, Dr. Leibowitz referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr. Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law as *Travelers* teaches, is not preempted by ERISA.

We conclude, therefore, that our reasoning and result in *Pappas I* are consistent with the Supreme Court's decision in

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nearby hospitals were capable of treating the patient's condition." (Reply Brief for Appellant at 2). Later, U.S. Healthcare recited that it "advised Dr. Dicker of three HMO PA participating hospitals in the area–Hahnemann, Temple and MCP–that could provide the same treatment available at Jefferson." (Reply Brief for Appellant at 4).

[6] We need not remand this matter for further findings. The record is undisputed and clear on the basic facts. Moreover, an appellate court may draw its own inferences from basic facts and arrive at its own conclusions when a finding of fact is simply a deduction from other facts and the ultimate fact in question is purely a result of reasoning. *Hutchison v. Sunbeam Coal Corp.*, 513 Pa. 192, 519 A.2d 385, 391 n. 6 (1986). The question of a decision's type--eligibility, treatment or mixed--is this sort of "ultimate fact", deduced from the basic facts through reasoning.

Pegram. Accordingly, we confirm our original disposition; the order of the Superior Court, reversing the grant of summary judgment to U.S. Healthcare is affirmed.[7] This matter is

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[7] With due respect to our learned colleague, we believe the dissent gives our analysis too broad a reading, and, it would seem, bases its disagreement with our holding on a question not raised in this appeal.

With regard to our analysis, there is no reason for concern that from this point forward, conflict preemption issues arising under ERISA will include no more than the "mere identification of whether a fiduciary act was involved". (Dissenting Opinion at 11). Our analysis of ERISA preemption in *Pappas I* was founded on the preemption provision of the statute, 29 U.S.C. 1144(a), and the Supreme Court's most recent teaching on the matter. This analysis, of course, continues to apply. It was the Supreme Court's request that we consider our decision in *Pappas I*, in light of its decision in *Pegram*, that necessitated our finding the conceptual relationship between a claim for breach of ERISA's fiduciary duties and the assertion that a state law claim for medical malpractice is preempted.

Turning to the main focus of the dissent, we read it as stating that this court should articulate a new and definitive duty or standard of care for HMO physicians making mixed eligibility and treatment decisions, and until that task is completed, issues of ERISA preemption cannot be resolved. Preliminarily, we note that the issue of duty or standard of care is not before us. We granted allocatur to consider U.S. Healthcare's motion for summary judgment, in which it asserted that the third party state law medical malpractice claims brought against it are preempted by ERISA *per se*. Whether the element of duty or the standard of care to which U.S. Healthcare should be held when third party plaintiffs attempt to prove their case differs from the duty or standard of care that Pennsylvania law imposes on non-HMO physicians is an issue that may remain for another day.

Moreover, the question the dissent poses conceivably presents a "Catch-22" form of circular reasoning. That is to say, any answer leads to ERISA preemption. On the one hand, according to the

remanded to the trial court for further proceedings consistent with this opinion.

Mr. Justice Saylor files a dissenting opinion.

SAYLOR, Justice, dissenting.

In response to the United States Supreme Court's remand directive for this Court to reconsider its prior decision in *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (Pa. 1998) ("*Pappas I* "),[1] in light of *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000)("*Pegram II*"), the majority concludes that *Pegram II* establishes that the third-party cause of action against Appellant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") is not preempted by ERISA, and that such cause should therefore be resolved according to state medical malpractice law. In so holding, the majority finds that *Pegram II 's* conclusion that ERISA does not establish a cause of action for breach of fiduciary duty predicated upon a managed care organization's "mixed eligibility" decisions, *see Pegram II*, 530 U.S. at 228-

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dissent, the application of a standard of care to an HMO's mixed eligibility and treatment decision that does not take into account an HMO's way of doing business arguably has more than a "tenuous, remote, or peripheral connection" with a covered plan, *Travelers*, 514 U.S. at 661, 115 S.Ct. 1671, and thus, is preempted. On the other hand, however, if a special standard of care is articulated for evaluating those decisions in which the peculiar pressures of an HMO's rationing decisions are considered, such a rule arguably regulates a plan's administration, and is also preempted. Under either scenario, ERISA invariably preempts a state law claim for medical malpractice arising out of an HMO's mixed eligibility and treatment decision. In our view, *Travelers* and *Pegram* do not contemplate such a result.

[1] I did not participate in the decision in *Pappas I*, as it was argued prior to my induction onto this Court.

29, 120 S.Ct. at 2154-55, equally establishes that such decisions are fully exposed to state tort law.

While I agree with the majority that nothing in *Pegram II* requires a full reversal of its prior disposition, I note that other courts have been more circumspect concerning the implications of *Pegram II* in relation to conflict preemption pursuant to ERISA. *See, e.g., Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 220 F.3d 641, 643-44 (5th Cir.2000) (stating that "we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and [our own precedent] held otherwise"). Accordingly, there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined,[2]

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[2] *Compare Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir.1999), *cert. denied*, 530 U.S. 1242, 120 S.Ct. 2687, 147 L.Ed.2d 960 (2000); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.1995); *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir.1995), *with Hull v. Fallon*, 188 F.3d 939 (8th Cir.1999), *cert. denied*, 528 U.S. 1189, 120 S.Ct. 1242, 146 L.Ed.2d 101 (2000); *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 5-7 (1st Cir.1999); *Parrino v. FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.), *cert. denied*, 525 U.S. 1001, 119 S.Ct. 510, 142 L.Ed.2d 423 (1998); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir.1997); *Jass v. Prudential Health Care Plan Inc.*, 88 F.3d 1482 (7th Cir.1996); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir.1995); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir.1993); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.1992). Although it has been suggested that the reasoning from *Pegram II* has effectively overruled the latter line of decisions, reserving ERISA preemption exclusively for the narrow category of claims implicating pure eligibility determinations by an HMO unrelated to medical diagnosis and decision making, the assessment in the aftermath of *Pegram II* has remained mixed. *See, e.g., Corporate Health*, 220 F.3d at 643- 44; *Schusteric v. United*

although further examination of this divide is beyond the scope of our mandate on remand. I do believe, however, that two points derive from *Pegram II* that are worthy of present consideration.

First, in my view, *Pegram II* gives cause for the exercise of a degree of caution on the part of state courts and legislators in terms of defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence. Second, I question whether a full, fair, and final resolution of the conflict preemption inquiry can be effected unless and until some more precise definition is afforded to any duties being ascribed to U.S. Healthcare under state tort law.

Regarding the first of these points, if ERISA preemption issues can arise only in connection with a specific exercise of fiduciary duty, the majority is correct that, once U.S. Healthcare's decision is deemed to be a mixed eligibility determination,[3] *Pegram II* establishes the absence of a fiduciary

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Healthcare Ins. Co., 2000 WL 1263581 (N.D.Ill. Sept.5, 2000).

[3] While U.S. Healthcare has argued that its decision to deny precertification of Mr. Pappas' transfer was a pure eligibility determination, the majority's conclusion that it was in fact a "when-and- how" sort of decision within the contemplated scope of the United States Supreme Court's framing of mixed eligibility decisions, *see Pegram II*, 530 U.S. at 228, 120 S.Ct. at 2154, finds a degree of support in *Pegram*. It should be noted, however, that the decision made in *Pappas* was far closer on the continuum to the eligibility form than that which was at issue in *Pegram*, since, under U.S. Healthcare's modified- IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in *Pegram*. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider

duty under ERISA, and preemption cannot apply. Certainly, however, the preemption clause itself is more broadly phrased; further, ERISA's civil enforcement provision, 29 U.S.C. § 1132, would appear to have been designed to protect the interests of plan participants more generally. Thus, while it is clear that the United States Supreme Court now subscribes to a narrower concept of preemption than that reflected in its earlier decisions, I am not so certain that the question of whether a state law claim challenges a fiduciary act is the sole, remaining, pertinent inquiry relative to preemption, particularly where the defendant may otherwise perform servicing functions integral to plan administration.

Accordingly, I would examine *Pegram II's* analysis more broadly than merely to identify the construct which it ultimately devised to determine fiduciary status. I view as significant the Supreme Court's deliberate, measured reasoning addressing and rejecting the central conclusions of the Seventh Circuit concerning an HMO's obligations under federal law,[4] with the Court's analysis subsuming the assessment that the duty of a

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through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. *See generally Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 2001 WL 292997, 2001 U.S.App. LEXIS 4903 (3d Cir. Mar. 27, 2001)(holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

[4] The Seventh Circuit had determined that an HMO's cost control incentive system or structure could serve as the predicate for a claim of breach of fiduciary duty under ERISA. *See Herdrich v. Pegram*, 154 F.3d 362, 373 (7th Cir.1998). In so holding, the majority employed strong language that was condemnatory of various HMO practices. *See, e.g., id.* at 375 (stating that "[i]n order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes").

managed care organization as stated by the Seventh Circuit was inimical to Congressional intent in fostering the health maintenance organization paradigm. *See generally* Phyllis C. Borzi and Marc I. Machiz, *ERISA and Managed Care Plans: Key Preemption and Fiduciary Issues,* SF28 ALI-ABA 371 (ALI-ABA Course of Study Oct. 2000) (stating that "[t]he Court in *Pegram* believed it faced an irreducible challenge to the essence of managed care"). Such rejection should not be overlooked, since, although the United States Supreme Court was discussing the issue of duty according to the federal fiduciary standard embodied in ERISA, state law duties which operate similarly would be no less disruptive. Moreover, the persistence of multiple state law standards broadly affecting otherwise permissible "rationing" decisions of managed care organizations, to the extent that such entities are viewed as serving as an important tool of plan administration, would also operate contrary to a central purpose of ERISA preemption, namely, to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657, 115 S.Ct. 1671, 1677-78, 131 L.Ed.2d 695 (1995). Thus, although certainly the dicta employed by the United States Supreme Court concerning preemption would appear to evidence its conclusion that ERISA may embody a degree of tolerance for some divergence among the legal standards applicable to managed care organizations across jurisdictions, *see, e.g., Pegram II*, 530 U.S. at 236- 37, 120 S.Ct. at 2158,[5] such passages should not be read as

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[5] Differing causes of action which have been asserted against managed care organizations across the nation include medical malpractice, negligence, breach of contract, breach of implied covenant of good faith and fair dealing, intentional/negligent infliction of emotional distress, wrongful death, unfair business practices, defamation, interference with contractual relations between physician and patient, antitrust violations, ostensible agency, and vicarious liability. *See* Comment, *The Ultimate Jigsaw Puzzle: ERISA*

completely independent of the Court's disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business.[6]

Preemption and Liability in the Utilization Review Process, 28 CUMB.L.REV. 403, 410 (1997-1998).

[6] In *Pryzbowski*, the Third Circuit recently made the above point as follows in relation to a delay-in-approval claim against an HMO:

A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*. *Cf.* 120 S.Ct. at 2156-57 (rejecting claims attacking financial incentives behind HMO structure, in light of congressional policy of promoting HMOs). *Pryzbowski*, 245 F.3d at ----. It should be noted that *Pegram II* tied various of its conclusions to the observation that the plaintiff had not alleged physical injury in the pertinent count of her complaint. Although this factor creates a substantial distinction between the claim under consideration in *Pegram* and that at issue here, I do not believe that the Court's concerns regarding allowance of the managed care form of business are completely inapposite when considering state law duties. Significantly, the particular framing of the count at issue in *Pegram* would appear to have been a consequence of the plaintiff's attempt to state a damages claim under ERISA (notably the plaintiff's overall complaint included allegations of concrete physical injury, including peritonitis). But just as a state law negligence claim can be recast in the form of a claim under ERISA, so the form of claim that the Supreme Court rejected as a matter of ERISA fiduciary analysis can effectively be restyled as a state law claim, and it is not a difficult matter to include an allegation of proximate harm in a forum with general jurisdiction to redress such injury. Indeed, several circuit courts of appeals have viewed various efforts to craft state law causes of action in just such a manner. *See, e.g., Jass*, 88 F.3d at 1489; *Schusteric*, 2000 WL 1263581.

As the United States Supreme Court recognized, fundamentally, managed care organizations ration treatment (or at least payment for treatment); assuming treatment is generally of positive effect, less treatment equates to greater risk (also assuming that patients cannot or will not fund treatment for which managed care will not pay);[7] and greater risk means higher incidence and more detrimental effect of injury and illness. If state law duties are imposed such that managed care organizations must provide compensation for all harm which can be proximately related to rationing, their viability will be determined by whether the cost of such harm ultimately exceeds the savings achieved by rationing in the first instance. Although certainly this is one form of risk spreading, it would not seem to be the form that Congress likely envisioned by sanctioning the managed care paradigm. Further, assuming that the managed care concept that has become integral as a service to ERISA plan administration is actually beneficial (as Congress appears to have believed), if costs ultimately exceeded savings in this particular equation, such benefit would be undermined. It would be difficult, then, to characterize state laws regulating rationing determinations which do not provide some reasonable mechanism for distinguishing between acceptable and unacceptable decisions as having only a "tenuous, remote, or peripheral connection" with covered plans, *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, assuming that the element of plan administration extends to managed care services to ERISA plans.

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[7] I recognize that various managed care strategies such as preventative care are designed to decrease costs by providing timely interventions which may obviate the need for more expensive treatment in the long term. Obviously, it would be ideal if such strategies sufficiently reduced the cost of health care to maintain profitability without other forms of more direct rationing. The Supreme Court's opinion seemed to accept, however, that, at least in the short term, broader forms of rationing are necessary to the managed care concept.

This leads to my second point, namely, that before a matter of conflict preemption can be finally determined in relation to a common law duty, the state courts should define, with reasonable particularity, the pertinent duty with which the managed care organization is to be charged.[8] Here, the third-party complaint frames a cause of action for "refus[ing] to authorize transfer of husband-plaintiff to a hospital selected by physicians at Haverford Community Hospital as being able to minister to husband-plaintiff's condition." Pertinent to such claim, the majority merely indicates that the United States Supreme Court has sanctioned the application of general principles of medical malpractice to managed care organizations. The result is to insulate the majority's holding that preemption is unwarranted within the United States Supreme Court's analysis from *Travelers* that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680. It should be recognized, however, that the asserted obligation of U.S. Healthcare to telephonically precertify out-of-network care on an emergency basis as selected by Haverford Community Hospital is not easily susceptible to measurement according to the general standard of care prevailing in the medical community pertaining to the rendition of medical services. In the first instance, medical personnel are not

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[8] In contrast, when the doctrine of complete preemption is asserted pursuant to Section 502 of ERISA in order to invoke federal jurisdiction, the plaintiff's well-pleaded complaint controls, since the analysis entails a comparison between a specific, federal cause of action and one asserted under state law. *See generally Bauman*, 193 F.3d at 160. A claim of conflict preemption under Section 514, however, asserted as a defense in a state court, questions whether a state law relates to ERISA, *see id.* Therefore, it is critically important in the Section 514 context that the pertinent state law obligation at issue be reasonably identified.

generally obligated to pay for medical services.[9] Further, U.S. Healthcare's obligations in respect to payment arise, at least initially, from its written commitments pertaining to the provision of health care services rather than from the general nature of a physician/patient relationship; thus, while managed care coverage is frequently comprehensive and must include access to emergency treatment, an HMO may not always commit (or pre-commit) to provide full payment for any and all services rendered on precisely the terms that may be dictated by the patient, a treating physician, or circumstance.[10] Additionally, by

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[9] The conclusions that physicians (or at least those not operating under a capitated arrangement) would not generally make decisions committing to payment responsibility finds at least colloquial support in the deposition testimony of the emergency-room physician who treated Mr. Pappas, who stated as follows:

A: My role as an emergency room physician is during an emergency to provide the best care, and I did not pay attention and did not concern myself with what would limit that care. I was trying to provide the best care for this patient. So did I, in an emergency situation, wonder whether the insurance was one over another? No.

Q: Well, was it your understanding that whether or not a patient has coverage doesn't affect whether or not a patient is treated, it just affects who pays for it after treatment is rendered?

A. From my point of view, the medicine comes first and the paperwork will be figured out later.

[10] One commentator argues this point as follows:
[T]here is powerful reason to recognize that a denial of funding does not *ipso facto* mean denial of care, nor is it necessarily the practice of medicine....

"[A]n adverse determination by a health insuring corporation means that the health insuring corporation will not pay for, reimburse, provide, deliver, arrange for, or otherwise make available the service in question.... It does not mean that the physician is precluded from

virtue of a managed care organization's assumption of the role of provider of or arranger for medical services, it may in fact assume additional duties giving rise to direct or indirect claims based in tort. In this regard, however, in Pennsylvania, the determination of duty in relation to a negligence cause of action is one of law subject to the following analysis:

> [T]he legal concept of duty of care is necessarily rooted in often amorphous public policy considerations, which may include our perception of history, morals, justice and society. The determination of whether a duty exists in a particular case involves the weighing of several discrete factors which include: (1) the relationship of the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foreseeability of the harm incurred; (4) the consequences of imposing a duty upon the actor; and (5) the overall public interest in the proposed solution.

Althaus v. Cohen, 562 Pa. 547, 553, 756 A.2d 1166, 1169 (2000).[11] While suggesting the direct application of medical

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providing the service or that the patient is precluded from obtaining the service from another source or through other means.... A physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation." Morreim, *Managed Care Financial Structures,* 35 TORT & INS.L.J. at 709 (citation omitted). These comments, of course, must be read in light of constraints which may be imposed by legislative enactments and agency regulations establishing a floor for the HMO's duties, by the health care infrastructure, and by individual financial resources. The point here is only that the conclusion that full payment is always required solely upon proof of appropriateness should not be treated by courts as a foregone one.

[11] As the foundation for this summary, Mr. Justice Castille quoted from the Court's prior decision in *Sinn v. Burd*, 486 Pa. 146, 404 A.2d

malpractice principles to a non-traditional provider of insurance and medical services making mixed eligibility/treatment decisions, this Court has not undertaken the requisite duty analysis in *Pappas I* or presently. Indeed, aside from the Court's general categorization of precertification of emergency care as "intertwined with the provision of safe medical care," *Pappas I*, 555 Pa. at 351, 724 A.2d at 893, the question remains one of first impression in this Court.[12]

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672 (1979), as follows:

> In determining the existence of a duty of care, it must be remembered that the concept of duty amounts to no more than the "sum total of those considerations of policy which led the law to say that the particular plaintiff is entitled to protection" from the harm suffered.... To give it any greater mystique would unduly hamper our system of jurisprudence in adjusting to the changing times. The late Dean Prosser expressed this view as follows:
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> These are shifting sands, and no fit foundation. There is a duty if the court says there is a duty; the law, like the Constitution, is what we make it. Duty is only a word with which we state our conclusion that there is or is not to be liability; it necessarily begs the essential question. When we find a duty, breach and damage, everything has been said. The word serves a useful purpose in directing attention to the obligation to be imposed upon the defendant, rather than the causal sequence of events; beyond that it serves none. In the decision whether or not there is a duty, many factors interplay: The hand of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall. In the end the court will decide whether there is a duty on the basis of the mores of the community, "always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind."

Althaus, 562 Pa. at 552-53, 756 A.2d at 1169 (quoting *Sinn*, 486 Pa. at 164, 404 A.2d at 681 (citations omitted)).

[12] A proper resolution of the duty question may depend upon a myriad

Thus, it can be seen that Pennsylvania's traditional construct for determining duty entails a much more precise inquiry than merely repositing such obligations within the rubric of "negligence laws," or "general healthcare regulation." *Pappas I*, 555 Pa. at 349, 352, 724 A.2d at 892, 894. Once fairly undertaken (and to the extent that the third-party plaintiff is asserting a duty on U.S. Healthcare's part in favor of the original plaintiff consistent with our joinder rules), the pertinent analysis should inform the conflict preemption determination (assuming, again, that something more is required than the mere identification of whether a fiduciary act was involved), with the final resolution to the question depending ultimately upon the manner in which the jury is charged on the subject.

It cannot escape notice that the above analysis, when applied to managed care organizations, necessarily entails precisely the sorts of judgments about socially acceptable medical risks that the United States Supreme Court declined to make in *Pegram II* for purposes of ERISA fiduciary analysis. *See Pegram II*, 530 U.S. at 221-22, 120 S.Ct. at 2150. It is difficult to disagree with the Supreme Court's assessment that the legislative branch presents a superior forum for the resolution of such duties, particularly in an arena as significant as managed

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of factors, including the nature and incentive structure of the managed care entity; the applicable legislative and regulatory requirements for services; the specific promises made at the outset of the contractual relationship; and whether and to what extent the policy and incentive structure operate to deprive patients of the option of making an informed decision as to whether to fund services themselves. In making such inquiries, our trial courts would be advised to consider the scope of the civil enforcement provisions of ERISA, 29 U.S.C. § 1132, since, in appropriate cases, transgression into this area may lead to the assertion of federal jurisdiction under the doctrine of complete preemption. *Compare generally Corporate Health*, 215 F.3d at 537, *with Bauman*, 193 F.3d at 161-62.

care;[13] nevertheless, where scant guidance is presented to courts of general redress, they remain charged with the obligation to address claims according to established paradigms.[14] This is particularly the case in the health care arena, since clearly states have a fundamental interest in ensuring quality of care, and it is therefore appropriate for them to implement measures to assure a degree of accountability on the part of managed care organizations. However, given a legislatively sanctioned system which allows for the rationing of treatment, the interest should be balanced against the purpose of managed care organizations to avoid effectively eliminating the infrastructure designed to enhance accessibility to medical resources.[15]

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[13] In fashioning a legislative solution, Congress could also consider the existing disparity between the treatment of claims against managed care organizations providing services to ERISA plans and those that do not. *See generally* Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing The Federal Legislative Solution,* 65 MO.L.REV. 405, 406-07 (Spr.2000).

[14] In Pennsylvania, the process of development and refinement of applicable duties as a matter of common law may be slow and cumbersome. Our trial courts, as courts of general jurisdiction, are responsible for the determination in the first instance, and cases filter through the intermediate appellate courts, with review being granted by this Court on a discretionary basis, such that the opportunity is provided for careful, informed developments. To the extent that departures from traditional forms are sanctioned, this may occur incrementally, as they will occur in the context of specific cases, rather than in the broader spectrum of the legislative process.

[15] Whether existing managed care organizations are effective in this regard is subject to differing interpretations. What is important here, however, is that Congress at least believed that there was a sufficient potential benefit to warrant express statutory authorization, *see generally Pegram II*, 530 U.S. at 232-35, 120 S.Ct. at 2156-57, and the central role which managed care occupies as a service provider to ERISA plan administration.

Contrary to the majority's footnote 7, I make no suggestion that this Court should presently articulate the duty or standard of care applicable to U.S. Healthcare's conduct. Rather, my point is that the Court should refrain at this juncture from directing that the cause of action against U.S. Healthcare must necessarily be assessed according to medical malpractice precepts and,[16] correspondingly, resolving the preemption inquiry on such basis. I fully acknowledge that any development concerning applicable duties would necessarily occur in the first instance at the common pleas level, *see supra* note 14, and would simply not foreclose any additional preemption assessment to the extent that a further consideration of duty would be appropriate in this case.

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[16] In its rebuttal to this dissent, the majority appears to ameliorate this difficulty by noting, "[w]hether the element of duty or the standard of care to which U.S. Healthcare should be held when third party plaintiffs attempt to prove their case differs from the duty or standard of care that Pennsylvania law imposes on non-HMO physicians is an issue that may remain for another day." However, the majority has not altered its textual assertion to the effect that "[U.S. Healthcare's decision] was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed ... through state medical malpractice law." In my view, these statements simply are not reconcilable. Moreover, the former statement appears to concede that there may be something left of the preemption inquiry, since it would be exceedingly difficult to determine whether a state-law duty is preempted unless and until the nature of such duty can be discerned.

Thus, in answer to the final characterization provided by the majority in its footnote 7, I am not advocating that "all roads lead to preemption." My concern is, rather, the avoidance of categorical statements regarding preemption until the road which is to be taken (that is, state law duties with which the defendant is being charged) can be identified for purposes of assessing the potential for conflict with the pertinent federal statutes and interests involved.

In summary, I agree with the majority that in the aftermath of *Pegram II* and *Travelers*, state laws having general application and relating to areas traditionally subject to state regulation are more likely to survive preemption challenges. I am not as certain, however, that the Supreme Court would confine the possibility of preemption solely to those cases involving pure eligibility determinations, and I believe that the reasoning of *Pegram II* contains at least inferential evidence to the contrary. In my view, *Travelers'* alteration in the course of ERISA preemption jurisprudence, which was emphasized by this Court in *Pappas I*, may evidence more than the fact of a stricter preemption construct. It may also demonstrate that the preemption inquiry may not be presently capable of distillation into questions answerable in a simple "yes" and "no" fashion. Rather, in absence of an appropriate legislative solution, the inquiry may have to endure a degree of further evolution in the law, perhaps substantial, at both the state and federal levels, particularly as it applies to an industry which occupies a societal role that touches the citizenry at large and is itself rapidly evolving.

In light of the above, I would modify this Court's original order to be without prejudice to U.S. Healthcare's ability to assert preemption arguments after such time as the trial court devises appropriate jury instructions.

APPENDIX B

Supreme Court of Pennsylvania.

Basile PAPPAS and Theodora Pappas, H/W, Plaintiffs,
v.
David S. ASBEL, D.O., Defendant.
Pennsylvania Hospital Insurance Co. (PHICO) and the Commonwealth of
Pennsylvania Medical Professional Liability Catastrophe Loss Fund (Cat Fund),
Defendants/Appellees,
v.
United States Healthcare Systems of Pennsylvania, Inc.,
Additional Defendant/
Appellant.

Argued April 30, 1997.
Decided Dec. 23, 1998.
Reargument Denied Feb. 12, 1999.

Before FLAHERTY, C.J., and ZAPPALA, CAPPY, CASTILLE, NIGRO, and NEWMAN, JJ.

OPINION OF THE COURT

CAPPY, Justice.

This is an appeal from the order of the Superior Court reversing the trial court's entry of summary judgment in favor of third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"). The issue on which this

court granted allocatur is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, *et seq.*, preempts the state tort law claims brought against U.S. Healthcare. For reasons which differ from those relied upon by the Superior Court, we find that ERISA does not preempt these claims. We therefore affirm the order of the Superior Court.

At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.

Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:15 p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however,

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[1] It is uncontested that U.S Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

In reviewing whether a trial court's award of summary judgment was appropriate, we view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre*, 532 Pa. 142, 144-145, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead Industries Assoc., Inc.*, 547 Pa. 224, 230, 690 A.2d 169, 171 (1997). As the issue presented in this case is one of law, our scope of review is plenary. *See Phillips v. A-BEST Products Co.*, 542 Pa. 124, 130, 665 A.2d 1167, 1170 (1995).

Our analysis begins with a review of the basic principles of preemption law. The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; ... any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const., art. VI, cl. 2. It is this clause which gives to the United States Congress power to preempt state law.

In determining whether state law is preempted by a federal law, a reviewing court is cautioned that such a review "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by ... Federal Act unless it [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407, 422 (1992) (citations omitted). Thus, Congress' intent is the "ultimate touchstone" in this analysis. *Id.*

A state law can be preempted in one of three ways. The first is where the United States Congress enacts a provision expressly preempting state law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n,* 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). Even where there is no explicit preemption provision, preemption will still be found where Congress has legislated the field so comprehensively that it has implicitly communicated the intent to occupy a given field to the exclusion of state law. *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 299-300, 108 S.Ct. 1145, 1150-51, 99 L.Ed.2d 316, 325 (1988). Finally, a state law will be preempted where a state law actually conflicts with federal law. *Id. See also Cellucci v. General Motors Corp.*, 550 Pa. 407, 706 A.2d 806, (1998).

It is this first method of preemption which is at issue in this matter. The express preemption provision in question states that "the provisions of this subchapter ... shall supersede any and all State laws[3] insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a).

None of the parties in this matter dispute that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against a health maintenance organization "relate to" an ERISA plan. U.S. Healthcare, however, cites to several United States Supreme Court cases from the 1980's and early 1990's as support for its contention that these claims should be preempted by ERISA.

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[3] "State law" was defined by Congress as including "all laws, decisions, rule, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1). It is uncontested that a decision handed down by a state court, which would enter the common law of that state, is a "State law" as defined by ERISA.

U.S. Healthcare is indeed accurate in its claim that the Supreme Court had given the ERISA preemption provision an almost breathtaking scope in the 1980's and early 1990's. The Court stated that the preemption provisions were "deliberately expansive". *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39, 49 (1987). The Court at that time held the opinion that "[t]he breadth of [§ 1144(a)'s] preemptive reach is apparent from that section's language." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490, 501 (1983). It declared that the words of the preemption provision were to be given their "broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388, 85 L.Ed.2d 728, 740 (1985) (citations omitted). In the vast majority of cases concerning ERISA preemption addressed by the Court during this period, it was found that the state laws being reviewed had some "connection with" or "reference to" the ERISA plan. Although the Court did concede that the ERISA preemption provision "perhaps [is] not the model of legislative drafting" that the Court would hope for, *Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552, 95 L.Ed.2d at 47, the Court in the 1980's and early 1990's did not admit to any possibility that the plain meaning of the words of the preemption provision could not be given effect.

The Court noticeably changed tack in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). In *Travelers*, the unanimous Court determined that a New York statute which required hospitals to collect surcharges from patients covered by all commercial insurers other than Blue Cross/Blue Shield was not preempted by ERISA. After years of striving to make sense of the plain language of the preemption provision, the Court frankly admitted that the text is "unhelpful". *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705. The Court

recognized that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.' " *Id.* at 655, 115 S.Ct. at 1677, 131 L.Ed.2d at 705 (citations omitted). The Court reasoned that the language of the preemption provision is so extensive that if the Court were to look merely to the bare language of the provision, the provision would for all intents and purposes be without limit--an intent which the Court would not ascribe to Congress. *Id.* The Court concluded that "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line here," and that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705.

The Court determined that the "basic thrust of the preemption provision ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657, 115 S.Ct. at 1677-1678, 131 L.Ed.2d at 706. It recognized fairly significant bounds on the preemption provision when it stated that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability. " *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709 (citation omitted). The Court also cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709 (citations omitted).

The cases following *Travelers* have continued this trend. In *California Division of Labor Standards Enforcement v. Dillingham Construction, NA., Inc.*, 519 U.S. 316, 117 S.Ct. 832,

136 L.Ed.2d 791 (1997), the majority relied upon *Travelers* to find that a California prevailing wage law was not preempted by ERISA. It is in the concurring opinion authored by Mr. Justice Scalia, however, that we find the most cogent recognition that the law of ERISA preemption had, in effect, been changed by *Travelers*. Mr. Justice Scalia opined that the cases from the 1980's and early 1990's, which were premised upon the now rejected notion that the plain language of the ERISA preemption provision could be given effect, were superannuated. He reproached the Court for not forthrightly acknowledging that the holdings of these older cases "have in effect been abandoned." *Id.* at 335, 117 S.Ct. at 843, 136 L.Ed. at 806 (Scalia, J., concurring). He believed that since *Travelers* recognized that literal interpretation of the provision "relate to" was unworkable, then earlier cases which concluded that the plain language of the preemption provision justified findings that the provision had "broad scope" and was "conspicuous for its breadth" were simply no longer good law. *Id.*

This new position on ERISA preemption was reiterated in *De Buono v. NYSA- ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997). The question presented in *De Buono* was whether a New York gross receipts tax could be applied to hospitals operated by ERISA plans. The Court again stated that the language "relates to" was unhelpful and that it must instead explore Congress' intent in enacting ERISA in order to determine if a state law would indeed fall within ERISA's preemptive scope. *Id.* at 812, 117 S.Ct. at 1751, 138 L.Ed.2d at 29. The Court determined that the gross receipts tax was not preempted by ERISA because it was "one of myriad state laws of general applicability that impose (sic) some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute.... Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is

pre-empted by the federal statute." *Id.* at 815-816, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31 (citations omitted).[4]

Thus, although U.S. Healthcare is correct when it states that U.S. Supreme Court decisions from the 1980's and early 1990's support its position that the preemption provision is to be read broadly, *Travelers* and its progeny have thrown the expansive holdings of those earlier cases into question.[5] We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning

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[4] We note that another case concerning ERISA preemption was decided the same day *De Buono* was handed down. *Boggs v. Boggs*, 521 U.S. 1138, 118 S.Ct. 9, 138 L.Ed.2d 1043 (1997). *Boggs*, however, does not lend anything to the analysis of the matter *sub judice*. In *Boggs*, the Court determined that Louisiana common law was preempted as it was in direct conflict with §§ 1055 and 1056 of ERISA, substantive provisions which limit the alienability of pension plan benefits from a surviving spouse. In this matter, it is not asserted that a claim of negligence lodged against an HMO is in conflict with any substantive provision of ERISA.

[5] U.S. Healthcare also cites to a number of circuit court decisions which have held that claims against HMOs are preempted by ERISA. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir.1995); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th. Cir.1993); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir.1993); *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir.1996). Yet, the bulk of these cases were handed down prior to *Travelers*. The only one of these cases which was decided subsequent to *Travelers*--*Cannon*--fails even to mention *Travelers*. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions.

contained within the *Travelers* line of cases, even though we recognize that the Court's earlier cases have not been expressly overruled.

Based upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not "relate to" an ERISA plan. As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709. Claims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.[6]

Furthermore, we believe that negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA]

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[6] The Superior Court below, in reasoning that ERISA does not preempt negligence claims lodged against HMOs, stated that "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted." *Pappas v. Asbel*, 450 Pa.Super. 162, 171, 675 A.2d 711, 716 (1996). The Superior Court concluded that Congress could not have intended to preempt that which it did not know would come into existence. We find that we are unable to adopt this reasoning that the modern day HMO was unforeseen by Congress when it drafted ERISA. Just one year preceding the enactment of ERISA, Congress enacted the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.* The HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs.

covered plans, as in the cases with many laws of general applicability," *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709, and therefore are not preempted. We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. As noted by the *De Buono* Court, an incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption. *De Buono*, 520 U.S. at 815-816, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31.

For the foregoing reasons, we conclude that ERISA does not preempt the claims in question. The order of the Superior Court is affirmed.[7]

Justice NIGRO files a concurring opinion.

NIGRO, Justice, concurring.

I concur in the result reached by the Majority. I agree that the *Traveler*'s line of cases in the United States Supreme Court supports the proposition that issues raising ERISA preemption are to be narrowly construed. I write separately, however, to explain why the present negligence claim against U.S. Healthcare falls outside that narrow construction and is therefore not preempted. Here, the defendant physician and

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[7] We also note that U.S. Healthcare puts great effort into arguing that it is not the negligent party here, and that Haverford and the physicians involved are solely responsible for the Pappas' injuries. U.S. Healthcare may ultimately be vindicated on these claims, but this is not the proper stage for these arguments. The issue with which we are concerned in this case is whether the claims against U.S. Healthcare are preempted; we have determined that they are not. It is now left for the fact-finder to determine if U.S. Healthcare's defenses to the negligence claims are valid.

hospital brought U.S. Healthcare into the action claiming that it was U.S. Healthcare's refusal to authorize a medically necessary transfer which caused plaintiff's ultimate injury. Based upon the facts set forth in the Majority Opinion, I find that U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan. Here, the parties are merely attempting to assert their already existing rights under the generally applicable state law of agency and tort. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.1995), *cert. denied.*, 516 U.S. 1009, 116 S.Ct. 564 (1995).

The federal courts have addressed issues similar to the present matter. *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D.Pa.1990), presented an analogous situation as the injured party sued her HMO after receiving negligent medical treatment from a physician on its approved list. The *Smith* court, in finding the plaintiff's action was not preempted, stated that such a state tort action did not " 'impact upon' an employee benefit plan or 'affect the Congressional scheme contained in [ERISA]'." *Id.* at 988.

Moreover, as the Third Circuit recently explained, "patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan." *Dukes*, 57 F.3d at 358. *Dukes* explains that ERISA is principally concerned with the various mechanisms and institutions involved in the funding and payment of plan benefits and was intended to provide each participant with a remedy in the event that promises made by the plan were not kept. *Id.* at 357. *Dukes* distinguishes between claims that the "quantum" of benefits promised were not provided, which *is* controlled by ERISA, and the "quality" of the benefits actually received, which is *not* controlled by ERISA. *Id.* *Dukes* concluded that "[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of

Congress as reflecting an intent that it remain such." *Id.* I would adopt the rationale of the *Smith* and *Dukes* decisions and find that the negligence action against U.S. Healthcare is not preempted.

Therefore, I believe the overall purpose for the enactment of ERISA, as well as subsequent case law, would indicate that the negligence claim against U.S. Healthcare does not fall under the aegis of the preemption clause. It is for these reasons that I find state negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans...." *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company et al.*, 514 U.S. 645, 661, 115 S.Ct. 1671, 1679, 131 L.Ed.2d 695, ---- (1995) (citing *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 n. 1, 113 S.Ct. 580, 583, n. 1, 121 L.Ed.2d 513 (1992)).

APPENDIX C

Superior Court of Pennsylvania.

Basile PAPPAS and Theodora Pappas, H/W
v.
David S. ASBEL, D.O. and Pennsylvania Hospital Insurance Co. (PHICO).
The COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)
v.
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.
Appeal of PHICO INSURANCE COMPANY and The Pennsylvania Medical Professional Liability Catastrophe Loss Fund.

Argued Jan. 9, 1996.
Filed March 15, 1996.
Reargument Denied May 23, 1996.

Before KELLY and HOFFMAN, JJ. and MONTEMURO, Senior Judge.*

MONTEMURO, Senior Judge:

This appeal lies from an order granting summary judgment to appellee, United States Healthcare, Inc. (USHC), on the basis that the third party complaint of appellant Haverford Community Hospital is preempted by Section 1144(a) of the

* Retired Justice assigned to Superior Court.

Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*

On May 20, 1990, Basile Pappas, a subscriber to USHC, an HMO provided through his wife's employment, presented himself at the offices of his primary care physician, Dr. David Asbel, complaining of neck and shoulder pain. The treatment administered was an intramuscular injection of steroids. By the next day, Mr. Pappas' condition had deteriorated significantly, and, unable to walk, complaining of numbness in his arms, chest, abdomen and legs, he was transported to appellant Haverford Community Hospital at 11:00 a.m. There, after examination and preliminary testing which revealed an abnormally elevated white blood cell count, Mr. Pappas was preliminarily diagnosed as suffering from a cervical epidural abscess which was compressing his spinal cord. Dr. Dickter, the emergency room physician responsible for Mr. Pappas' care, determined that the case constituted a neurologic emergency requiring further, immediate diagnosis and treatment at a university hospital with more extensive facilities than those available at Haverford.

After telephone consultation with Dr. Asbel, as well as Haverford's staff neurologist and neurosurgeon, arrangements were made by 12:30 to transfer Mr. Pappas to Thomas Jefferson University Hospital, which, possessing a spinal cord trauma unit, was able to assure Mr. Pappas' immediate admission. However, at 12:40 the ambulance service which was to transport Mr. Pappas informed the physicians at Haverford that as Jefferson was not an approved facility, authorization for Mr. Pappas' removal there was not forthcoming from USHC. At 12:50, Dr. Dickter telephoned USHC in an attempt to obtain authorization, and to do so quickly in view of the nature of the emergency. At 1:05, Dr. Dickter was informed by USHC that, after review, authorization for treatment at Jefferson was still being denied, but that Mr. Pappas could be removed to Hahnemann University, Temple University or Medical College of Pennsylvania. The

USHC physician[1] who had made this decision refused to speak directly to Dr. Dickter, despite several requests that he do so, and after USHC was informed that Mr. Pappas' condition could worsen or become permanent. Rather, USHC's position was communicated through administrative personnel. Since Dr. Asbel expressed a preference for Hahnemann, that facility was contacted immediately but advised Haverford at about 2:20 p.m. that it would not have information on its ability to receive Mr. Pappas for at least another half hour. MCP was then reached and within minutes notified the physicians that it could accept Mr. Pappas, who was ultimately transported there at about 3:30 p.m. Mr. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Mr. Pappas brought suit against Asbel and Haverford, claiming various forms of malpractice as to the former, and as to the latter, negligence in causing an inordinate delay in transferring him to a facility equipped and immediately able to address the neurological emergency, thus exacerbating the compression of the spine which caused his quadriplegia. Haverford then filed a third party complaint against USHC, joining it as a party defendant for its refusal to authorize the transfer of Mr. Pappas to the hospital selected by the Haverford physicians, and adopting the negligence claims lodged against it in the original complaint. In his answer and new matter, Dr. Asbel filed a cross claim against USHC seeking contribution and/or indemnity. After filing both Answer and New Matter and Preliminary Objections, which failed to mention preemption, USHC successfully filed a motion for summary judgment alleging that the third party complaint should be dismissed, having been preempted by § 1144(a) of ERISA. This appeal

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[1] The record does not reveal the field of specialization of this physician, a Dr. Liebowitz [*sic*].

followed,[2] presenting the question of whether ERISA was correctly determined to preempt Haverford's claim, characterized by appellant as a state law claim unrelated to ERISA or employee benefits, against USHC.[3]

In reviewing a grant of summary judgment we must determine whether, in view of the pleadings, depositions, answers to interrogatories, admissions on file, together with any affidavits, any genuine issue of material fact exists in the case, and, if not, whether the moving party is entitled to judgment as a matter of law. Moreover, the moving party's right to such a judgment must be clear and free from doubt. *Musser v. Vilsmeier Auction Co., Inc.*, 522 Pa. 367, 562 A.2d 279 (1989); Pa.R.C.P. 1035.

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[2] Mr. Pappas' claims against Dr. Asbel and Haverford were settled by agreement of the parties, and Haverford's interests vis a vis USHC are now represented by the Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Catastrophic Loss Fund.

[3] There is no question that USHC is an employee benefits plan as defined by ERISA, 29 USCS § 1002(1):

> The terms "employee welfare benefit plan" and welfare plan mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, (A) medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefits described in section 3023(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions)

29 U.S.C. § 1144(a) reads in pertinent part as follows:

> Except as provided in subsection (b) of this section, the provisions of this title ... shall supersede any and all State laws *insofar as they* may now or hereafter *relate to* any employee benefit plan ... (emphasis added).

It may, without fear of contradiction, be asserted that the Supremacy Clause, United States Constitution, Art. VI, expressly or by implication commands preemption of a state law where such law conflicts with federal law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Commission*, 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). It is also well settled that ERISA's supersession provision is vast in its application. *Ingersoll-Rand v. McClendon,* 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). However, the question still remains as to the precise reach of the phrase "insofar as they ... relate to ..." In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983), the United States Supreme Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 97; 103 S.Ct. at 2900. The trial court in this matter found that the allegations in Haverford's third party complaint all "f[e]ll within the rubric of administration of an employee benefit plan" because they concerned specific actions taken by USHC, namely its refusal to approve Mr. Pappas' transfer to a facility where the care he needed was available immediately as the emergent nature of his condition required.

Because the limitations supplied by the cases attempting to define "relate to" are necessarily vague, the district and circuit courts which have considered the matter of HMO involvement are split on the precise extent of ERISA's reach. A number of federal court cases impose preemption on efforts to hold an HMO liable for injuries resulting from certain of its decisions on the basis that any attempt to seek redress constitutes an attack on

the administration of the HMO, the position adopted by the trial court herein, and thus imposes a restriction such as the Act seeks to avoid. *See, e.g., Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir.1993), *cert. denied,* 510 U.S. 1045, 114 S.Ct. 694, 126 L.Ed.2d 661 (1994) (claim against HMO for denying surgical precertification preempted by ERISA); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (1992), *cert. denied,* 506 U.S. 1033, 113 S.Ct. 812, 121 L.Ed.2d 684 (1992) (claims against HMO for failure to provide hospitalization to expectant mother resulting in death of unborn child). All of these cases have in common the reasoning that the state law claims involved necessarily "relate to" administration of the plans in question and are therefore preempted under the broad sweep of § 1144(a).

The United States Supreme Court, however, albeit in dealing with factual settings which differ from the sorts of claims involved in these cases, has refined the "relate to" language, thus truncating it to some extent. In *Mackey v. Lanier Collection Agency and Service,* 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988), attendant upon a finding that a state garnishment action against participants in an ERISA plan providing vacation and holiday benefits was not preempted, the Court noted:

> ERISA plans may be sued in a second type of civil action as well. These cases--lawsuits against ERISA plans for run of the mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan--are relatively commonplace. Petitioners and the United States (appearing here as amicus curiae) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA § 514(a).

Id. at 833, 108 S.Ct. at 2187 (emphasis added).

In the recent case of *New York Blue Cross v. Travelers Insurance Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), the Court has indicated that § 1144(a) may well be further limited. There, the Court examined a New York statute which requires hospitals to collect surcharges from patients covered by designated commercial insurers and imposes a surcharge on certain HMO's, but exempts from the surcharges those patients insured by a Blue Cross/Blue Shield plan. In holding that the surcharge provisions do not "relate to" employee benefit plans, the Court noted that the language of ERISA is so expansive as to be, for all practical purposes, infinite: unless read in conjunction with the structure and purpose of the statute as a whole, the words of limitation, "insofar as they ... relate to ...," are not limiting at all, and Congress' intention must be interpreted as a sham. *Id.* at ----, 115 S.Ct. at 1677. Rather, the Court determined to "go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* The Court then observed that "[t]he basic thrust of the preemption clause ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," *id.* at ----, 115 S.Ct. at1677-78, that is, to protect it from conflicting directives. However, the Court went on to note that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at ----, 115 S.Ct. at 1680. The Court extrapolated from its findings that "a law operating as an indirect source of merely economic influence on administrative decisions ... should not suffice to trigger preemption." *Id.*

This last is especially pertinent to the question presented here despite the variance in context. What is at issue is a negligence claim identical to the one lodged against Haverford by Mr. Pappas in the underlying complaint. The type of recovery sought is based on negligence attributable to the delay

occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries. Decisions such as that made by USHC concerning where Mr. Pappas might receive treatment are propelled by dollar savings, not the protection of worker's rights, in this case the right to the most effective medical care, which was the original focus of ERISA. In fact, the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations.

Considerations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted. It cannot therefore be argued that the type of recovery sought here was deliberately excluded from the Congressional schema in order to protect ERISA plans from conflicting directives which would, in attempting to control expenses, affect medical judgments. A tort claim such as that advanced here is, in fact, "an indirect source of merely economic influence on administrative decisions." *Id.* To find that such claims are preempted because they may interfere with what is in essence a business decision made in the financial interests of a commercial entity is inconsistent with the intention of ERISA and should not "suffice to trigger preemption." *Id.*

This conclusion is consistent with cases in which courts found that a particular state claim is not preempted, based on the rationale that the state law involved affects ERISA in an indirect manner, or is so tenuous or remote as to obviate the necessity for preemption. *Greenblatt v. Budd*, 666 F.Supp. 735, 741 (E.D.Pa.1987) (common law action for misrepresentation by employee whose pension benefits were denied after company merger not preempted.) To make such a determination, it is the state statute which must be examined, and an assessment made of whether the action represents exercise of a classically

important state function preempted neither expressly or impliedly by ERISA. *Id.* Contrast, *Memorial Hospital System v. Northbrook Life Insurance Company*, 904 F.2d 236 (5th Cir.1009) (action for deceptive trade practices by health care provider against plan trustees not preempted, because enforcing allocation of risks between commercial entities conducting business in a state is a classically important state interest, and because health care provider is not a party to plan.) General health care regulation is, as has already been noted, traditionally an area of state concern. *New York Blue Cross*, supra.

While decisions of the federal district courts and courts of appeal, including those of the Third Circuit, are not binding on Pennsylvania courts, even where a federal question is involved, *Breckline v. Metropolitan Life Insurance Company*, 406 Pa. 573, 578, 178 A.2d 748, 751 (1962), they are both persuasive as to federal questions, *Chiropractic Nutritional Associates, Inc. v. Empire Blue Cross and Blue Shield, Inc.*, 447 Pa.Super. 436, 445, 669 A.2d 975, 980 (1995), and those of the Third Circuit are appropriate for this court to follow where the United States Supreme Court has not spoken. *Id.* In *Dukes v. US Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir.1995) (claims for direct negligence of HMO remanded to state court for determination of whether preemption was mandated),[4] the Third Circuit recognized that "Quality control of benefits ... is a field traditionally occupied by state regulation, and we interpret the silence of Congress as reflecting an intent that it remains so." *See also, Independence HMO, Inc. v. Smith*, 733 F.Supp. 983

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[4] Appellee argues that this case is inapposite as it concerned only the issue of whether it was proper to remove the case to federal court based on ERISA's preemption provision--no decision was reached as to whether this provision actually applied. However, as appellant points out, the court was not able to articulate any plan-created right that was threatened by the plaintiffs' state law negligence claims. Had it been able to do so the decision as to preemption would not even be regarded as equivocal; the claim would have been dismissed.

(1990) (state court action for medical malpractice under ostensible agency theory not preempted by ERISA).

In *Krashna v. Oliver Realty Inc.*, 895 F.2d 111 (3d Cir.1990), albeit in another context, the Court of Appeals for the Third Circuit stated that in order to show that what purports to be a state law claim is completely preempted by federal statute, two factors must be shown:

> First, "the statute relied upon by the defendant as preemptive [must] contain [ ] civil enforcement provisions within the scope of which the plaintiff's state claim falls." ... The federal statute must subsume the interest vindicated by the state law, not the remedy provided.... Second, there must be "a clear indication of a Congressional intention to permit removal despite the plaintiff's exclusive reliance on state law."

Id. at 114, quoting *Railway Labor Executives Ass'n. v. Pittsburgh & L.E. R.R.*, 858 F.2d 936, 942 (3d Cir.1988). *See also, Plucinski v. I.A.M. National Pension Fund, et al*, 875 F.2d 1052 (3d Cir.1989) (In accountancy malpractice case brought by a plan, the conclusion was reached that ERISA does not generally preempt state professional malpractice claims.)

ERISA's civil enforcement provision, § 1132(a)(1)(B), permits beneficiaries of employee welfare plans to "recover benefits due ... under the terms of the plan," "to enforce ... rights under the terms of the plan or to clarify rights to future benefits under the terms of the plan." As the *Dukes* court observes,

> Inherent in the phrases "rights under the terms of the plan" and "benefits due ... under the terms of [the] plan" is the notion that plan participants and beneficiaries will [by means of litigating tort claims] receive something to which they would not otherwise be entitled. But patients enjoy the right to be free from medical

malpractice regardless of whether or not their medical care is provided through an ERISA plan. *Id.* at 358.

This court has ruled that negligence claims are not preempted by ERISA, as they are not "related to" it. *See, McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied,* 532 Pa. 664, 616 A.2d 985 (1992) (suit based on liability of HMO for negligence of agent/physician and on intentional misrepresentation or fraud by HMO itself); *DeGenova v. Ansel,* 382 Pa.Super. 213, 555 A.2d 147 (1988) (suit based on vicarious liability of HMO for the negligence of its agent/physician). Nor are these claims covered by ERISA's civil enforcement provisions. The *DeGenova* court specifically found that the "appellants were not seeking ERISA benefits or claiming improper distribution or administration of ERISA benefits," *Id.* at 219, 555 A.2d at 150, and thus preemption did not apply.

The negligence claims at issue here too have, in fact, no connection to the benefit scheme which Congress sought to protect by preempting laws tending to produce conflicting systemic demands; ERISA is in no way implicated by the claim that USHC negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer. Appellants do not seek benefits denied, because Mr. Pappas was transferred to a hospital capable of supplying the needed services; they do not seek to challenge the administration of the Plan, again because there is no complaint that USHC did not perform its duties. Rather, the argument is that USHC performed its duties in a negligent manner given the exigent nature of the emergency. Finally, if the original complaint had claimed that USHC was vicariously liable because of the negligence of its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question under *McClellan* and *DeGenova* that the claim would withstand preemption.

As the *Corcoran* court points out, to conclude that the preemption of all other claims was incorporated into Congress' intent in enacting ERISA necessarily assigns to Congress the concomitant intent to deprive plaintiffs injured by such negligence of any remedy, state or federal, for serious errors perpetrated by HMO's. However, the Supreme Court of the United States, in analyzing the application of preemption clauses in other statutes, found it "difficult to believe that Congress would, without comment, remove all judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corporation,* 464 U.S. 238, 251, 104 S.Ct. 615, 623, 78 L.Ed.2d 443 (1984) (Award of punitive damages arising out of escape of plutonium from federally licensed nuclear facility not preempted by Atomic Energy Act). *See also, United Construction Workers v. Laburnum Construction Corporation*, 347 U.S. 656, 74 S.Ct. 833, 98 L.Ed. 1025 (1954).

We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system which inheres in USHC's review process, to foreclose recovery to plan beneficiaries injured by negligent medical decisions. We therefore conclude that the negligence claims against appellee are not preempted by ERISA.

The question then becomes what, if any, impact the procedural posture of this case has on the implementation of the preemption provision. The trial court concedes that the "no relation" theory may be a valid one, but concludes that because Haverford Hospital and not Mr. Pappas joined USHC as a party defendant, no theory of recovery which would otherwise be available could apply. Pa.R.C.P. 2255(d) dispenses with such a distinction:

> The plaintiff shall recover from an additional defendant found liable to him alone or jointly with the defendant as though such defendant had been joined as a defendant

> and duly served and the initial pleading of the plaintiff had averred such liability.

See also, Solomon v. Cedar Acres East, Inc., 455 Pa. 496, 317 A.2d 283 (1974).

The effect of a third party complaint joining an additional defendant is thus to make the additional defendant "immediately subject to the plaintiff's claim in every respect and with the same force and effect as if the additional defendant had been originally named as the defendant" in the plaintiff's complaint. *3 Standard Pennsylvania Practice 2d* (1994), § 14:359. The character of the claim does not alter with the procedure used to present it.

Accordingly, we reverse the trial court's order granting summary judgment and remand for further proceedings consistent with this Opinion.

APPENDIX D

IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEDORA PAPPAS, Plaintiffs	:	No. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL, and UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. Defendants	:	

ORDER

KEELER, J. FILED:

AND NOW, this 3rd day of June, 1994, upon consideration of the motion for Summary Judgment filed by United States Healthcare Systems of Pennsylvania, Inc. (USHC), the various responses filed by the other parties and the memoranda submitted, it is hereby ORDERED that USHC's motion for Summary Judgment is GRANTED.

BY THE COURT:

/s/ Charles C. Keeler, J.
CHARLES C. KEELER, J.

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEODORA PAPPAS, his wife	:	No. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL	:	
vs.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	

OPINION

KEELER, J. FILED:

I. FACTS

On or around May 20, 1991, the plaintiff, Basile Pappas, presented himself at the offices of Dr. David Asbel, complaining of neck and shoulder pain. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of medication. Despite this treatment, plaintiff alleges that his condition worsened. The following morning his deterioration manifest itself by rendering Mr. Pappas immobile and by causing numbness in his extremities. He was transported via ambulance to the Haverford Community Hospital ("Haverford") on the morning of May 21, 1991. The plaintiffs provided the hospital with information regarding HMO-PA in order to satisfy the hospital of financial responsibility. Both Mr. and Mrs. Pappas

subscribed to HMO-PA through an employees' health benefits plan provided to Mrs. Pappas by her employer, The Charming Shoppes. HMO-PA is owned by additional defendant U.S. Healthcare Systems of Pennsylvania, Inc. ("USHC"). He was admitted at approximately 11:00 a.m. to the hospital's emergency room. Dr. Steven J. Dickter examined Mr. Pappas and ordered a blood study. The analysis revealed an elevated white cell count. These results in conjunction with the patient's subjective complaints and physical ailments led Dr. Dickter to the conclusion that Mr. Pappas was suffering from an epidural abscess which pressed upon Mr. Pappas' spinal column.

Dr. Dickter consulted with Dr. Slater, a neurologist at Haverford who concurred that the situation constituted a neurologic emergency. This determination was also confirmed by a consultation with Dr. Yalon, a Haverford neurosurgeon. Given the circumstances, Dr. Dickter felt it would be in the patient's best interest to receive treatment at a "university" hospital. Dr. Dickter made arrangements to transfer Mr. Pappas to Jefferson University Hospital for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that Jefferson was not an approved hospital for HMO-PA. Ten minutes later, Dr. Dickter contacted HMO-PA to inquire as to Jefferson's status as an approved facility. Nearly 15 minutes later, HMO-PA responded to Dr. Dickter's inquiry and advised him that Jefferson was not an approved facility, but that the patient could be transferred either Hahnemann, Temple or Medical College of Pennsylvania ("MCP").

Dr. Dickter then telephoned Dr. Asbel and sought his preference concerning the patient's destination. Dr. Asbel expressed a preference for treatment by Dr. Black at Hahnemann. Dr. Dickter promptly telephoned Hahnemann to advise them of the emergency situation and to secure information regarding the transfer into Dr. Black's care. After the passage of five minutes, Dr. Dickter again called and found

that his contact person was still checking on intensive care unit bed space availability. At approximately 2:20 p.m. Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before any information could be provided as to Hahnemann's ability to accept Mr. Pappas as a patient. Dr. Dickter then telephone Dr. Mucci at MCP to ascertain whether the patient could be transferred to that facility. Within ten minutes Dr. Mucci returned the call and expressed that the patient could be accepted. Ultimately, Mr. Pappas was transported to MCP.

This lawsuit was brought as a consequence of the injuries allegedly sustained by Mr. Pappas resulting from delay in treatment while Haverford's staff attempted to make appropriate arrangements for care of the plaintiff's neurologic emergency. Plaintiff alleges that the delay exacerbated his spinalcord compression which resulted in quadriplegia. Haverford filed a third party complaint joining USHC as a third party defendant for their refusal to authorize a transfer of Mr. Pappas to a hospital selected by the physicians at Haverford. Moreover, the third party complaint suggests that USHC is liable over to Haverford for any award which might result from this action. Dr. Asbel, in his answer and new matter, filed a cross claim seeking contribution and/or indemnity from the third party defendants, USHC.

II. PROCEDURAL POSTURE

Third party defendant, USHC, has filed a motion for Summary Judgment alleging that the third party complaint filed by Haverford must be dismissed under the preemption provisions of the Federal Employment Retirement Income Security Act of 1974 (ERISA). *See* 29 U.S.C. § 1001, *et seq.* (1990). Haverford has responded by asserting that this court lacks jurisdiction to either determine whether ERISA preempts state law or the substance of HMO-PA's preemption arguments.

Any intelligent analysis of the issues raised must be predicated on an understanding of the nature of the ERISA provisions and a fundamental understanding of the nature of preemption. As such, we will address those issues first.

III. DISCUSSION

As a threshold matter, the court must determine whether it has jurisdiction to render any decision in regard to the present litigation. Haverford conveniently ignores a number of cases which decided issues involving ERISA claims. Inferentially, the fact that our appellate courts would consider the substance of such matters suggests that no legal impediment exists which divests a state court of jurisdiction over such issues. *See McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied*, 532 Pa. 664, 616 A.2d 985 (1992); *DeGenova v. Ansel*, 382 Pa.Super. 213, 555 A.2d 147 (1988).

Haverford has failed to identify any specific provision of ERISA which would divest this court of jurisdiction. Instead, it directs our attention to language in the statue which provides that Federal courts, with certain exceptions, shall have exclusive jurisdiction of civil actions brought by the Secretary of Labor or by a plan's "participant, beneficiary or fiduciary." 29 U.S.C. § 1132(e)(1). Certainly, Haverford's cross-claim is in the nature of a civil action. However, Haverford cannot maintain that its third party action is brought "by the Secretary of Labor or by a Plan's 'participant, beneficiary or fiduciary'." All of these parties (as defined by ERISA) are individuals. No corporate entity such as Haverford may avail itself of the exclusive jurisdiction of the Federal courts under this exclusive jurisdiction of the Federal courts under this specific provision. *See* 29 U.S.C. § 1002(7) (participant defined), 1002(8) (beneficiary defined) & § 1109 (fiduciary defined).

Having determined that this court possesses jurisdiction to decide the preemption issue we may now address the substance of the argument.

Under the Federal Constitution legislation enacted by the Federal government "shall be the supreme Law of the Land ..." U.S. Const. Art. VI, cl.2. Thus, any state law which conflicts with federal law is "without effect." *Maryland v. Louisiana*, 451 U.S. 725, 746, 101 S.Ct. 2114, 2128, 68 L.Ed.2d 576, 595 (1981). Nevertheless, any issue arising under the supremacy clause assumes that the historic police powers of the individual states are not to be superseded by federal legislation unless it is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947).

The intent of Congress may be "explicitly stated in the statute's language or implicitly contained in its structure in purpose." *Jones v. Rath Packing Co.*, 430 U.S, 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604, 614 (1977). In the absence of an express congressional command, state law is preempted to the extent it conflicts with federal law. *See Pacific Gas & Elec. Co. v. Energy Resources Conservation and Development Comm'n.*, 461 U.S. 190, 204, 103 S.Ct. 1713, 1722, 75 L.Ed. 2d 752, 765 (1983). State laws are also rendered ineffectual if a federal law so thoroughly occupies a legislative field as to make it reasonable to infer that Congress left no room for the States to supplement it. *Fidelity Fed. Savings & Loan Assoc'n. v. De La Cuesta*, 458 U.S. 141, 153, 102 S.Ct. 3014, 3022, 73 L.Ed. 2d 664, 675 (1982).

ERISA specifically provides that it "shall supersede any and all state laws insofar as they may now or hereafter related to any employee benefit plan." 29 U.S.C. § 1144(1). The language of the ERISA statute sweeps broadly by superseding all state laws relating to any employee benefit plan. *Morales v. Trans World Airlines, Inc.*, __ U.S.__, 112 S.Ct. 2031, 2037, 119

L.Ed.2d 157, 168 (1992) (breath of scope of ERISA unmistakably relies on "express preemption and construction of the phrase 'relates to'"); *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990) ("deliberately expansive"); *FMC v. Holliday*, 498 U.S. 52, 58 111 S.Ct. 403, 407, 112 L.Ed.2nd 356, 364 (1990) ("conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490, 501 (1983) (breadth of ERISA's "preemptive reach is apparent from [its] language").

Nevertheless, the preemption clause does not bar all claims. *See* e.g. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833, 108 S.Ct. 2182, 2187, 100 L.Ed.2d 836, 846 (1988) (state garnishment of ERISA welfare Benefit Plan not preempted; such plans may be subject to suit for state law violations, contractual obligations and torts which are unrelated to the plan's administration).

The crux of the issue then seems to be whether ERISA's preemption provision which provides that any and all state laws are superseded insofar as they "relate to any employee benefit plan" bar Haverford's claims against USHC. *See* 29 U.S.C. § 1144(a). Haverford's third party complaint attempts to establish the liability of USHC by showing that USHC "refused to authorize transfer of [Mr. Pappas] ... to a hospital selected by physicians at Haverford ... as beging able to minister to him." *See* Haverford's third party complaint at paragraph 7. In addition, the third party complaint incorporates by reference the allegations of paragraph 24 of plaintiff's original complaint. That paragraph asserted that Haverford ... was negligent in failing to transfer [Mr. Pappas] ... to another medical facility in a prompt and timely fashion and that Haverford ... inordinately delayed the transfer. *See* plaintiff's complaint at paragraph 24. All of these allegations fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision.

We must therefore conclude that Haverford's efforts to pursue its third party complaint are barred.

Haverford relies upon inapposite caselaw in support of its contentions. The imposition of a local income tax on employees despite their status as ERISA participants does not implicate a relationship to any employee benefit plain in a substantive sense. See *Firestone Tire and Rubber Co v. Neusser*, 810 F.2d 550 (6th Cir. 1987). Nor does the application of a local tax affect the administration of an employee benefit plan in any substantive sense; thus, mandating the preemption of the action. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, 47-48 (1987) (decisional common law cause of action for improper benefit claim processing barred by ERISA because it relates to employee benefit plan).

A number of courts have held that state claims are preempted by ERISA where suit is filed to hold an HMO responsible for injuries resulting from the HMO's own negligent administration of cost containment procedures and funding decisions. *Kuhl v. Lincoln Nat'l. Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ERISA preemptions plaintiff's claim against HMO for denying surgical precertification), *cert. denied* 114 S.Ct. 964 (1994); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1331 (5th Cir.) (ERISA preempts claim for erroneous medical decision rendered in context of determining plan benefits, *cert denied* 113 S.Ct. 812 (1992); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290-91 (E.D.Pa 1992) (ERISA preempts direct liability claim for failure to fund medical device). In all of these cases, preemption was based upon the fact that the failure to pay a benefit claim or preapprove a procedure possessed an obvious connection or reference to a benefit plan and therefore related to it. Other courts have decided that ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability generally or ostensible agency specifically. *Elesser, supra,* at 1290 (plaintiff's claim alleging vicarious liability of

HMO for actions of position acting ostensible as HMO's agent not preempted); *Independent HMO v. Smith*, 733 F.Supp. 983, 988 (E.D.Pa. 1990) (same). These cases apply the rationale that the negligence claims have no relationship to a denial of rights under the benefit plan since they do not affect the regulatory scheme devised by Congress in ERISA. Thus, such claims are not sufficiently "related to" ERISA such as to warrant preemption. *See generally Boyd v. Albert Eistein Medical Center*, 377 Pa.Super. 609, 619-20, 547 A.2d 1229, 1234 (1988) (adopting Restatement (Second) of Agency section 267 which outlines the theory of ostensible agency). Given the procedural posture of this case and the fact that Haverford Hospital and not the plaintiff joined USHC to the action, neither of these theories is applicable in this case.

Here, Haverford Hospital seems to suggest that USHC is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under USHC's programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan. As such, Haverford's motion for Summary Judgment must be denied.

Haverford's final argument concerning ERISA's civil enforcement scheme demonstrates a basic misconception of the ERISA statute. Clearly, certain enumerated and defined parties may seek to invoke ERISA's civil enforcement remedies. 29 U.S.C. § 1132. However, Haverford seems to confuse standing to maintain an action with preemption. The fact that ERISA provides standing to specified categories of individuals which limits redress does not translate to a waiver of preemption. In any event, as observed previously, Haverford, as a corporate entity, possesses no standing to maintain a civil action under ERISA.

For the foregoing reasons, USHC's motion for Summary Judgment was granted.

BY THE COURT

/s/ Charles C. Keeler
CHARLES C. KEELER, J.

Supreme Court, U.S.
FILED
SEP 19 2001
OFFICE OF THE CLERK

No. 01-200

IN THE

Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE COMPANY, and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA, EASTERN DISTRICT

BRIEF IN OPPOSITION FOR RESPONDENTS

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COUNTERSTATEMENT OF QUESTION PRESENTED

In enacting ERISA and its preemption clause, did Congress clearly intend to truncate the states' traditional roles in the regulation of the quality of health care services and in the enforcement of health care malpractice tort rights by preempting and effectively eradicating claims for personal injury damages caused by the negligence of HMO-employed health care service professionals in the performance of their duties to provide or to arrange for appropriate medical care for the beneficiaries of ERISA plans?

STATEMENT PURSUANT TO RULES 14.1(b) AND 29.6

The petition accurately lists the parties to the proceedings.

Respondent Pennsylvania Hospital Insurance Corporation, In Rehabilitation, ("PHICO") is a subsidiary of PHICO Group, Inc., which is ovned in its entirety by the Health Alliance of Pennsylvania, and is currently in Rehabilitation.

Respondent The Commonvealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") is a statutorily created executive agency of the Commonwealth of Pennsylvania.

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COUNTERSTATEMENT OF THE CASE

A. Introduction

This case involves a state law medical malpractice personal injury damages claim against an HMO medical services provider for its alleged negligence in delaying appropriate emergency medical treatment for a subscriber to the HMO, Basil Pappas, who was unquestionably entitled to that treatment by any capable medical facility, whether or not the facility had a contractual service relationship with the HMO. The HMO, petitioner U.S. Healthcare, functioned as a provider of pre-paid medical services to the ERISA plan which had been established by the employer of the subscriber's wife. The ERISA plan is not a party to this case. There is no claim in this case against the ERISA plan, and no claim challenging the terms of the plan or seeking payment by the ERISA plan. There is no evidence that the HMO acted as the ERISA plan's administrator. The obligations of the HMO in this case are no different from its obligations toward any of its subscribers, whether or not they are beneficiaries of an ERISA plan.

This is the second time that this case has reached your Honorable Court. On the first occasion, your Court granted certiorari, summarily vacated the judgment of the Pennsylvania Supreme Court in *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) ("*Pappas I*"), and remanded for reconsideration in light of *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000). *United States Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hospital Insurance Co.*, 530 U.S. 1241 (2000). On remand, the Pennsylvania Supreme Court received new briefs from the parties and from the

Solicitor General on behalf of the Secretary of Labor and then did exactly what your Court directed it to do, *Pappas v. Asbel*, 768 A.2d 1069 (Pa. 2001) ("*Pappas II*").

In its second attempt to obtain review of the merits of this case by your Honorable Court, petitioner roots its analysis and its arguments largely on its selective reading of what the Pennsylvania Supreme Court said in *Pappas I* and on the shift that *Pegram* inspired in the position of the Solicitor General between *Pegram* and *Pappas II*.[1] Petitioner also attempts to draw an irreconcilable conflict between *Pappas II* and the decision of the United States Court of Appeals for the Third Circuit in *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.2d 266 (3d Cir. 2001) and decisions from other jurisdictions.

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1. Petitioner points to the Pennsylvania Supreme Court's statement, arguably *dicta*, in *Pappas I*, that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." (App. 29a). Petitioner unaccountably ignores the clarifying next sentence of the court's opinion, which expressed its narrow *holding* that claims that an HMO caused bodily harm by negligently delaying the delivery of the medical services which it promised to provide were claims regarding the provision of safe medical care and that Congress did not intend to preempt the states from adjudicating those claims (App. 39a). Likewise, petitioner stresses selective quotations from the brief filed by the Solicitor General with your Honorable Court, but fails to provide your Court with the brief that the Solicitor General filed with the Supreme Court of Pennsylvania in *Pappas II*, in which the government candidly acknowledged that it no longer adhered to the statements which the petition now disinters. *See* p. 4a of the Solicitor General's brief attached as the appendix to this brief in opposition ("Because the Secretary's views of this case have changed in light of *Pegram*, and because this is the first opportunity to express those views since *Pegram*, the Secretary has a strong interest in participating in this stage of the proceeding.").

What is now at issue, however, is what was said by the Pennsylvania Supreme Court in *Pappas II*. Because what that court said in *Pappas II* comports fully with the controlling decisions of your Court, respondents PHICO and the CAT Fund respectfully ask that your Honorable Court either deny the HMO's petition for writ of certiorari, as your Court did in *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001) and in *U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000), or that your Court grant the petition and summarily affirm the judgment of the Pennsylvania Supreme Court in *Pappas II*. If necessary, your Court could note its disapproval of the analysis of *Pryzbowski* and the other cases advocated by petitioner, or could distinguish *Pryzbowski,* as involving a delay in making a benefit determination, and directly related to plan administration, as opposed to a negligent medical judgment concerning which independent provider was capable of supplying the care needed within the time it was needed.

B. Factual Background

The opinion of the Pennsylvania Supreme Court accurately sets forth the factual background. App. pp. 2a-3a, 12a-13a.[2] However, because the issue arose on U.S. Healthcare's motion for summary judgment in the trial court (as opposed to a petition for removal), the facts and their inferences must be viewed in the light most favorable to the respondents.

As the Pennsylvania Supreme Court duly noted and considered, Dr. Dickter, the Haverford emergency room physician who personally attempted to persuade the HMO

2. The Solicitor General's brief noted a similar factual background (Respondents' App., pp. 15-16a).

to change its veto against transporting Mr. Pappas to the non-affiliated hospital that he had ascertained was ready to promptly and properly treat Mr. Pappas, testified that he emphasized to the HMO representatives that the situation confronting Mr. Pappas was a neurological emergency, and that his pleas for the HMO to reevaluate and change its decision were reviewed and disapproved by the HMO's Medical Director, Dr. Liebowitz. *See* Reproduced Record, pp. 70a-72a, 77a (deposition testimony of Dr. Dickter), and pp. 93a (typewritten transcript of emergency room chart).

When viewed in the proper perspective, the record facts of this case suggest that the ultimate decision by the HMO's Medical Director was completely or predominately a medical determination, either that Mr. Pappas' condition was not a true emergency or that there was no need to have him treated at a hospital that was not affiliated with the HMO. There is no question in this case that Mr. Pappas alleged a medical condition which required emergency medical care. There is also no question that Mr. Pappas was entitled to have U.S. Healthcare pay for treatment at any capable facility if his situation was an emergency. Nor is there any claim for the payment of such emergency service.[3]

C. Procedural History

Basile and Theodora Pappas filed a complaint against David Asbel, D.O. and Haverford Community Hospital ("Haverford"), alleging, *inter alia*, that those defendants were negligent in failing to timely diagnose and treat Mr. Pappas'

3. The Solicitor General's brief noted that coverage for emergency care was required by both federal and state law, and that the facts indicated that the HMO's decision was a mixed treatment and eligibility decision, Respondents' App., pp. 15-17a.

spinal cord compression. App. pp. 47a-58a. Haverford joined petitioner U.S. Healthcare as an additional defendant. App. pp. 59a-61a. Haverford alleged that U.S. Healthcare "refused to authorize transfer of husband/plaintiff to a hospital selected by physicians at Haverford Community Hospital." App. p. 60a, para. 7. Furthermore, by incorporation of paragraph 24 of plaintiffs' complaint (App. p. 60a, para. 6), Haverford alleged that HMO-PA negligently:

a. fail[ed] to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. delay[ed] inordinately in transferring the patient, keeping him at the Haverford Community Hospital during which time his spinal cord compression continued with resultant damage to the patient's spinal cord. App. pp. 54a-55a.

After discovery, U.S. Healthcare filed a motion for summary judgment, claiming that Haverford's complaint must be dismissed under ERISA. The trial court granted the motion for summary judgment, finding that all of Haverford's claims against the HMO fell within the confines of administration of an employee benefit plan, and therefore, were barred under the ERISA preemption provision. App. p. 41a. Ultimately, a settlement agreement was reached among the original parties, and respondents PHICO and the CAT Fund were substituted for Haverford as the real parties in interest against petitioner U.S. Healthcare. App. pp. 45a-46a.

On the respondents' appeal, the Superior Court of Pennsylvania reversed the trial court's decision and remanded

the matter for further proceedings on the merits of the claim. *Pappas v. Asbel,* 675 A.2d 711, 717 (Pa. Super. 1996); App. pp. 18a-33a.

On the HMO's appeal, the Pennsylvania Supreme Court affirmed the reversal and remand ordered by the Pennsylvania Superior Court, but for different reasons, *Pappas I.* The Pennsylvania Supreme Court eschewed the Superior Court's emphasis on the HMO's cost-containment interest (App. p. 39a, n.6).

In determining the approach to be taken in the resolution of the HMO's immunity-through-preemption defense, the Pennsylvania Supreme Court perceived that your Honorable Court's decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ("*Travelers*"), *California Div. of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316 (1997) ("*Dillingham*"), and *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997) ("*DeBuono*"), marked a narrowing departure from the broader approach to "relate to" that your Court earlier took in determining ERISA preemption in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) ("*Pilot Life*"). App. pp. 35a-39a.

Following the approach mapped by *Travelers*, *Dillingham*, and *DeBuono*, the Pennsylvania Supreme Court concluded that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App. p. 39a. More specifically, the court held that claims that an HMO caused bodily harm by negligently delaying the delivery of the medical services which it promised to

provide were claims regarding the provision of safe medical care and that Congress did not intend to preempt the states from adjudicating those claims (App. p. 39a):

> . . . As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S. Ct. at 1680, 131 L. Ed. 2d at 709. Claims that an HMO was negligent when it provided contractually guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.

Thereafter, your Honorable Court granted the HMO's petition for writ of certiorari, summarily vacated the Pennsylvania Supreme Court's order, and remanded the matter for reconsideration in light of *Pegram*.

On remand, the Pennsylvania Supreme Court accepted new briefs from the parties and from the Solicitor General on behalf of the Secretary of Labor.

In his brief to the Pennsylvania Supreme Court in *Pappas II*, the Solicitor General reached the same conclusion, stating,

> Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the

> involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.

(Respondents' App., pp. 16-17a) The Solicitor General's brief also noted that Justice Nigro concluded in his concurring opinion in *Pappas I* that the HMO's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan," (Respondents' App., pp. 17a, n.11) an observation which the majority opinion in *Pappas II* acknowledged to have "anticipated the Supreme Court's reasoning in *Pegram* (App. p. 6a, n.3).

Appropriately considering *Pegram* and the briefs and record before it, the Pennsylvania Supreme Court again concluded that the claims against the HMO were not preempted. The court confirmed its original disposition by affirming the judgment of the Superior Court and remanding the case for further proceedings in the trial court. App. p. 14a.

In reaching that disposition, the court first recounted the remand directive from your Honorable Court, the pertinent history and facts, and its earlier analysis. App. pp. 1a-6a. It then turned to and thoroughly analyzed *Pegram*. App. pp. 7a-11a. It then drew from *Pegram* and from

Travelers the recognition that a personal injury claim which was based on a "mixed eligibility and treatment decision" by an HMO was not preempted. App. 11a. Finally, the Pennsylvania Supreme Court turned to the record and, viewing the facts and drawing inferences in the light most favorable to the parties which opposed the HMO's motion for summary judgment, perceived that the HMO's Medical Director did not simply make a simple decision on coverage, but rather rejected another doctor's clinical judgment and rendered a mixed eligibility and treatment decision which was not preempted by ERISA. App. pp. 12a-13a.

Justice Saylor filed a dissenting opinion. He recognized, however, that *Pegram* did not require a reversal of the court's decision, and that claims based upon mixed eligibility and treatment decisions were not preempted by ERISA. App. pp. 16a, 17a-18a, 28a-29a. Expressing his belief that the court had to address two additional points relating to the duty or the standard of care for HMO's, Justice Saylor sought to have the court leave the preemption question open to allow the HMO to assert preemption after the trial court had devised proper jury instructions regarding the HMO' duty or standard of care. App. pp. 17a-29a. The majority of the Pennsylvania Supreme Court noted that the questions regarding the HMO's liability were not raised by its preemption claim and were yet to be determined in the case. App. p. 14a, n.7; *see also* p. 40a, n.7.

REASONS TO DENY THE PETITION OR TO SUMMARILY AFFIRM THE DECISION OF THE PENNSYLVANIA SUPREME COURT

A. The Approach Taken By The Pennsylvania Supreme Court Regarding The Applicability Of ERISA And Its Preemption Clause Correctly Follows The Approach Most Recently Taken By Your Honorable Court

Petitioner first posits that your Honorable Court should review the decision of the Pennsylvania Supreme Court because that decision failed to follow *Metropolitan Life* and *Pilot Life* and instead followed *Travelers* and *DeBuono*. However, even a casual comparison of those cases confirms that the Pennsylvania Supreme Court correctly perceived a shift in your Court's approach to a determination of what state laws "relate to" an ERISA plan. Your Court's more recent decision in *Pegram* reinforces that conclusion.

The earlier *Metropolitan Life/Pilot Life* approach emphasized the general nature of the ERISA preemption clause's "relates to" phrase and the structure of the ERISA preemption and exception clauses: if the matter had some impact on an ERISA plan, then it may be preempted, unless it fell within the scope of the insurance exception to preemption. Thus, under the original approach delineated in *Metropolitan Life/Pilot Life*, conduct that does or might affect an ERISA plan is presumptively preempted unless it falls within the scope of the exceptions to ERISA's broad preemption provision. *Metropolitan Life, supra*, 471 U.S. at 739; *Pilot Life, supra,* 481 U.S. at 47-48.

In contrast, the later approach delineated in *Travelers* and *DeBuono*, began with the recognition that emphasis on the "relate to" phrase can produce a sweep of federal preemption far beyond the scope intended by Congress when it enacted ERISA, because virtually everything can be connected to an ERISA plan. *Travelers, supra*, 514 U.S. at 655; *DeBuono, supra,* 520 U.S. at 813. The *Travelers/ DeBuono* analysis also recognized that the operative presumption is against preemption, not for preemption, and it placed on the party claiming preemption "the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law'." *DeBuono*, 520 U.S. at 814, quoting *Travelers*, 514 U.S. at 654. When Congress enacted ERISA, all of the states had traditionally allowed, and regulated to varying extents, health care malpractice claims. "And yet there is not so much as a hint in ERISA's legislative history or anywhere else that Congress intended to squelch these state efforts." *Travelers*, 514 U.S. at 665. As the Solicitor General stated in his brief to the Pennsylvania Supreme Court, "In determining whether ERISA preempts a state law, the Court should start with the presumption that Congress did not want to preempt a state's historic police powers in areas such as regulation of medical care, unless there is a clear and manifest intent to the contrary." Respondents' App., p. 4. Notably absent from the HMO's petition is a citation to a specific prohibition against health care malpractice claims asserted against health care providers, either in ERISA or in the Department of Labor's implementing regulations.

Petitioner attempts to make much of the fact that your Honorable Court did not overrule *Metropolitan Life* and *Pilot Life* when it decided the later cases. However, your Court had no reason to overrule those cases when it decided

Travelers and *DeBuono*. *Metropolitan Life* presented state action that squarely affected the substantive provisions of an ERISA plan. *Pilot Life* presented a state action that squarely conflicted with ERISA's contractual enforcement provisions. Because the state actions in those cases clearly "related to" ERISA plans and plainly conflicted with federal provisions, your Court had no reason to denounce those decisions. *See DeBuono*, *supra*, 520 U.S. at 813.

The HMO's arguments miss two additional points. First, your Honorable Court did take a different approach in its later cases after acknowledging that the approach taken in its earlier cases was unworkable. Second, your Court followed the *Travelers/DeBuono* approach when it decided *Pegram*. In that case, your Court stated that *Travelers* "throws some cold water on the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, *supra*, 120 S. Ct. at 2158. The Court also saw no congressional intent to usurp, and no benefit in judicially federalizing, state malpractice claims. *Id.* Furthermore, your Court reiterated its holding *Travelers*, *supra*, 514 U.S. at 654-655, that, "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram*, 120 S. Ct. at 2158. That holding echoed and crystallized your Court's earlier observation in *Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988), that commonplace tort claims were not displaced by ERISA.

The restrictive approach taken by your Honorable Court in *Pegram*; its reaffirmation of a presumption against ERISA preemption of state medical malpractice claims; and its

finding no clear congressional purpose to federalizing those claims are factors that reinforce the accuracy of the Pennsylvania Supreme Court's decisions to approach the preemption determination not from the preemption presumption suggested by *Metropolitan Life/Pilot*, but rather from the more recent perspectives that preemption is not to be presumed but must be explicitly established by its proponent, and that preemption does not obtain simply because there may be some tenuous connection between the HMO defendant and an ERISA plan.

B. The Decision Of The Pennsylvania Supreme Court That The Claim At Issue Was Not Preempted, Because It Was A Mixed Eligibility And Treatment Claim, Is Fully Consistent With Your Honorable Court's Decision In *Pegram*

The core of petitioner's argument to your Honorable Court are the propositions that the claim against it simply "challenges a straightforward and commonplace ERISA plan determination," and that the claim "falls squarely within the preemptive scope of Sections 502(a) and 514(a) of ERISA," because the claim "arises from and directly relates to the administration of benefits under the ERISA-governed health plan, and provides an alternative enforcement mechanism to ERISA," Petition, p. 12. Those propositions, however, cannot be accepted for several reasons.

First, the claim at issue involves only U.S. Healthcare, which is an entity that is completely distinct from the ERISA plan that Mrs. Pappas' employer created. Neither the ERISA plan nor the employer are parties to this case.

Second, there is no evidence that U.S. Healthcare was the administrator of the employer's ERISA plan. To the contrary, U.S. Healthcare's sole apparent role was to serve as a health care service provider to the beneficiaries of the employer's ERISA plan.

Third, the claim in this case does not directly implicate a provision of the employer's ERISA plan. It may fairly be taken as given that the plan's terms included health care benefits for its beneficiaries, and it may be fairly assumed that the plan's terms described the quantity of those benefits in a general manner that allowed the plan to contract with a service provider, such as an HMO or an insurer, to enroll the plan's beneficiaries, who so desired, as members of the HMO or as insureds. However, there is no evidence that the plan's terms delineated the particulars of the insurer's coverage or the scope of the HMO's program. Moreover, there is no evidence that the plan's terms established the quality standards for the services to be delivered by the health care provider, and no evidence that the plan's terms immunized the provider from personal injury or malpractice claims.

Fourth, the case does not simply involve a challenge to a benefits determination. The damages which respondents seek from petitioner are contribution to the personal injury damages suffered by Mr. and Mrs. Pappas. There is no claim for payment for hospitalization or even for ambulance transportation, and there is no claim for injunctive or declaratory relief. Moreover, there is no genuine question that the terms of the HMO's service contract entitled Mr. Pappas to be treated for an emergency at any hospital, not just at the hospitals within U.S. Healthcare's system. To put it bluntly, there was no legitimate question of coverage

for emergencies by an out-of-network hospital.[4] Rather, the focus of the claims against U.S. Healthcare in this case centers on the medical treatment aspects of its conduct, in particular on the implication that its decision rested on its Medical Director's medical determination, such as that Dr. Dickter's clinical diagnosis of an emergency situation was not correct, or that its contract hospitals were as available and as appropriate as the hospital which Dr. Dickter initially selected, or the like.[5]

Fifth, the medical treatment aspects of the HMO's conduct are not subject to ERISA, because they are at least "mixed" decisions under *Pegram*. Petition, pp. 16-17. Petitioner declares that subjecting it "to state tort law liability

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4. To the extent that U.S. Healthcare argues that coverage was its sole concern, that argument simply underscores its negligence in failing to properly consider the medical circumstances of Mr. Pappas' situation.

5. In its brief to the Pennsylvania Supreme Court, the government reached the same conclusion, stating,

> Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.

(Respondents' App., pp. 16-17a)

for providing coverage at network hospitals rather than an out-of-network hospital would thus be contrary to – not consistent with – *Pegram*." Most pointedly, however, your Court held in *Pegram* that such decisions are not subsumed by ERISA, even if made by an HMO in its capacity as an administrator of an ERISA plan. Petitioner's assertion cannot stand in the face of your Court's explicit statement to the contrary:

> The kinds of decisions mentioned in Herdrich's ERISA count and claimed to be fiduciary in character are just such mixed eligibility and treatment decisions: physicians' conclusions about . . . making referrals to . . . facilities other than [the HMO's]; about proper standards of care, . . . the reasonableness of a certain treatment, and the emergency character of a medical condition.

Pegram, *supra*, at 2154-2155.[6]

Finally, the ultimate result that U.S. Healthcare seeks in this case is a declaration of immunity from negligence. Although the arguments that your Honorable Court rejected in *Pegram* posited some tangential benefits to federalizing mixed decisions and malpractice claims, such as faster docket movement and potential awards of attorneys fees, U.S. Healthcare's arguments that the claims made against it in this case have to be dismissed under *Pilot Life* raise no comparable universal benefits. Instead, what U.S. Healthcare

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6. The Solicitor General's brief to the Pennsylvania Supreme Court pointed to the same language in *Pegram* to support the government's contention that the HMO's decision in this case was a "mixed treatment and eligibility decision." Respondents' App., p. 17a.

seeks would benefit only itself and other HMOs: complete immunity from any malpractice claim that can possibly be linked to some ERISA plan.

Further consideration of that argument elicits an additional distinction between this case and *Pilot Life* that U.S. Healthcare's arguments fail to appreciate. When Congress entered the field of employee benefit plan regulation through the enactment of ERISA, the legislative choice was between state diversity and federal uniformity, not between a contractual cause of action and no cause of action whatsoever. Congress gave ERISA participants and beneficiaries some contractual cause of action and some relief akin to the cause of action and the relief asserted by the claimant in *Pilot Life*. Because the *Pilot Life* plaintiff retained the federal cause of action and remedies provided by ERISA with respect to the insurer's denial of benefits, the task of your Honorable Court in that case was to determine whether that cause of action and its remedies could be enlarged by the state cause of action and remedy. However, in the context of a health care malpractice action against a service provider, such as this case, the pertinent considerations are very different. In essence, U.S. Healthcare urges the courts to rule that Congress obliterated a traditional state field of law *without providing a parallel federal field of law* as it did with respect to the essentially contractual terms of ERISA.[7] Without a stronger indication of congressional intent beyond what U.S. Healthcare divines from the absence of a malpractice cause of action in ERISA, no court should assume that Congress intended to eradicate state health care malpractice actions against service providers such as the HMO in this case.

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7. That the congressional usurpation was limited to essentially contractual matters is evident in the remedial provisions of ERISA's Section 502(a), as set forth in 29 U.S.C. § 1132(a).

C. Whatever Need There May Be For Further Clarification By Your Honorable Court Can Be Delivered By A Grant Of Certiorari And Summary Affirmance Of The Decision Of The Pennsylvania Supreme Court

1. Like The Pennsylvania Supreme Court, Most Lower Courts Have Correctly Understood And Followed Your Honorable Court's Decisions In *Travelers*, *DeBuono*, And *Pegram*

In the past, lower court decisions with respect to the extent of ERISA's preemption have varied markedly and incompatibly. Notably, nearly all inconsistencies occurred prior to the decisions handed down by your Honorable Court in *Travelers, DeBuono* and *Dillingham*. Importantly, however, as one author has recognized, *Travelers* "provides much needed guidance for courts asked to identify the line delimiting state laws that Congress intended to preempt . . ." K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 Yale J. Reg. 255, 290 (1996).

In addition to the decision of the Pennsylvania Supreme Court, *Travelers*' influence is now emerging in decisions of other lower courts, limiting ERISA preemption of state law tort claims. These courts have applied *Travelers* and its progeny to come to a more functional definition of "relate to". *See, for example, Corporate Health Ins. v. Texas Dept. of Ins.* 215 F.3d 526, 535 (5th Cir. 2000) (holding that a state law allowing suit for claims of negligent delivery of medical services and imposing vicarious liability on managed care entities is not preempted); *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp.2d 1013 (C.D. Ill. 1999)

(noting that a claim for failure to diagnose myocardial infarction would not be preempted under § 514(a)); *Prudential Ins. Co. of America v. Doe*, 46 F. Supp.2d 925 (E.D. Mo. 1999) (determining that claims for emotional distress and invasion of privacy are not preempted); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 U.S. Dist. LEXIS 3101, *10 (N.D. Tex. March 11, 1999) (concluding ERISA preemption does not apply to claims based upon quality of care received); *Moreno v. Health Partners Health Plan*, 4 F. Supp.2d 888, 893 (D. Ariz. 1998) (finding "no relation between an action for medical malpractice and the recovery of benefits or the clarification of rights to future benefits under an ERISA plan."); *Ray v. Value Behavioral Health, Inc.*, 967 F. Supp. 417, 423 (D. Nev. 1997) (finding claims for negligence, invasion of privacy and infliction of emotional distress are "exactly the sort of generally applicable personal injury laws that § 514 of ERISA does not preempt."); *Dykema v. King*, 959 F. Supp. 736, 739 (D.S.C. 1997) (agreeing that a claim of direct liability for failure to diagnose pulmonary embolism does not "relate to" an ERISA plan); *Nascimento v. Harvard Community Health Plan*, No. 94-2543, 1997 Mass. Super. LEXIS 166, *27 (Mass. Super. Sept. 26, 1997) (holding that the provisions of ERISA do not preempt a claim for failure to provide bone marrow transplantation therapy); *Nealy v. U.S. Healthcare*, 93 N.Y.2d 219-220 (1999) (noting claims for failure to take reasonable steps to provide for patient's timely treatment by specialist do not "relate to" the administration of an ERISA plan). Each of these decisions is compatible with "the general tenor of recent [Supreme] Court cases that reemphasize the strength and vitality of the presumption against ERISA pre-emption of laws of general application." R. Charrow and L. Greenlees, *ERISA Pre-Emption – A Law in Search of a Doctrine*, Health L. Dig., March 1999 at 14.

In like manner, the United States Court of Appeals for the Third Circuit recognized the *Travelers* approach to determining claims of ERISA preemption and rejected the HMOs' claims in similar factual cases in *Dukes v. U.S. Healthcare,* 57 F.3d 350 (3d Cir.), *cert. den.*, 516 U.S. 1009 (1995), *In Re: U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), *cert. den.*, 530 U.S. 1242 (2000) ("*Bauman*"), and in *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir. 2000), *cert. den. sub nom*, *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001).

2. Any Confusion Caused By The Third Circuit's Most Recent Decision In *Pryzbowski* And In Other Decisions That Apparently Depart From Your Honorable Court's Decisions In *Travelers*, *DeBuono*, And *Pegram* Can Be Resolved By Summary Affirmance Of *Pappas II* And Disapproval Of The Contrary Decisions

As the petition for writ of certiorari suggests (Petition, p. 18), the analysis and decision of the Third Circuit in *Pryzbowski* could be read to conflict with the analysis and decision of the Pennsylvania Supreme Court in *Pappas II.* Yet, since the delay in that case which allegedly caused the harm, was not a delay caused by a negligent medical judgment to refer a patient to providers incapable of providing needed care in a timely fashion, but rather was a delay in the benefit determination process itself, *Pryzbowski* is arguably distinguishable as a benefit determination. Even if read to conflict with *Pappas II*, the precedential value of *Pryzbowski* is highly suspect because it is a panel decision which facially conflicts impermissibly with the prior and binding Third Circuit panel decisions in *Dukes*, *Bauman*, and *Lazorko*, despite the *Pryzbowski* panel's attempts to distinguish those

cases. Furthermore, the precedential value of *Pryzbowski* is questionable because its analysis and decision appears clearly at odds with your Honorable Court's pronouncements in *Pegram*.

Petitioner criticizes the Pennsylvania Supreme Court for not addressing *Pryzbowski* "in the face of Justice Saylor's discussion of *Pryzbowski* in his dissent" (Petition, p. 19). But it was, most likely, the institutional weakness of *Pryzbowski* that prompted Justice Saylor to relegate it to footnotes and to attempt to distinguish it (App. note 3 at pp. 17a-18a; note 6 at p. 20a), and why the majority opinion did not see fit to discuss it. Moreover, while the *Pryzbowski* panel interpreted and applied *Pegram* differently from the majority of the Pennsylvania Supreme Court, Justice Saylor "agree[d] with the majority that nothing in *Pegram* requires a full reversal of its prior decision" (App. 16a).

To the extent that your Honorable Court believes that further clarification of the law with respect to personal injury malpractice claims against HMO health care service providers is necessary, respondents respectfully suggest that the message can be delivered quickly and forcibly by the Court's simply granting the petition for writ of certiorari, summarily affirming *Pappas II* in light of *Pegram*, and noting its disagreement with *Pryzbowski* and similar cases.

CONCLUSION

Because the decision of the Pennsylvania Supreme Court is fully consistent with your Honorable Court's holdings in *Travelers*, *DeBuono*, and *Pegram*, respondents respectfully suggest that your Court deny the HMO's petition for writ of certiorari in this case, as it did in *Aetna U.S. Healthcare v. Lazorko*, 121 S. Ct. 2552, 2001 U.S. LEXIS 4732 (2001), and in *U.S. Healthcare, Inc. v. Bauman*, 530 U.S. 1242 (2000).

In the alternative, respondents respectfully suggest that your Honorable Court provide further guidance to the lower courts and resolve the apparent discrepancies among their reported decisions by granting the petition for writ of certiorari, summarily affirming the decision of the Pennsylvania Supreme Court in light of *Pegram*, and noting its disagreement with the apparently contrary decisions, such as *Pryzbowski*.

Respectfully submitted,

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APPENDIX

APPENDIX — BRIEF FOR THE SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR AS *AMICUS CURIAE* DATED SEPTEMBER 22, 2000

IN THE
SUPREME COURT OF PENNSYLVANIA

No. 0098 E.D. Appeal Docket 1996

BASILE PAPPAS & THEODORA PAPPAS, H/W,

Plaintiffs,

v.

DAVID S. ASBEL, D.O.,

Defendant,

PENNSYLVANIA HOSPITAL INSURANCE CO. (PHICO) and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND),

Defendants/Appellees,

v.

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Additional Defendant/Appellant.

BRIEF FOR THE SECRETARY OF THE UNITED STATES DEPARTMENT OF LABOR AS AMICUS CURIAE

Appendix

On Remand from the Order of the United States
Supreme Court, No. 98-1836, dated June 19, 2000

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Appendix

STATEMENT OF THE QUESTION INVOLVED

Whether, in light of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), Section 514(a) of the Employee-Retirement Income Security Act (ERISA), 29 U.S.C. 1144(a), preempts a state law action arising from a health maintenance organization's alleged negligence in denying authorization for certain emergency medical treatment under an ERISA-governed plan.

* * *

INTEREST OF THE SECRETARY OF LABOR

At the request of the United States Supreme Court, the Solicitor General, on behalf of the Secretary, filed a brief expressing views on whether to grant United States Healthcare's (USHC's) certiorari petition in this case, which sought review of this Court's decision in *Pappas* v. *Asbel*, 555 Pa. 342, 724 A.2d 889 (1998).[1] The government argued

1. The Secretary of the United States Department of Labor has a strong interest in preemption issues under the Employee Retirement Income Security Act (ERISA) because the Secretary is charged with administering and enforcing Title I of ERISA. See 29 U.S.C. 1002(13) (defining "Secretary"), 1132(a)(2), (5), 1135. The Secretary has participated as amicus curiae in a number of cases raising ERISA preemption issues in federal and state courts in the health care context. See, *e.g.*, *Nealy v. US Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1999); *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), cert. denied, 120 S. Ct. 2687 (2000). The Solicitor General of the United States has also presented the Secretary's views to the United States Supreme Court in such cases. See, *e.g.*, *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995).

that, under existing law, the 1998 decision was overbroad and incorrect as applied to the facts as we understood them. The government asked the United States Supreme Court either to grant certiorari or to dispose of USHC's certiorari petition in light of the Court's disposition of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), which was then pending before the Court.

On June 19, 2000, the United States Supreme Court vacated this Court's decision and remanded for reconsideration in light of *Pegram*. See *United States Healthcare Sys. of Pa., Inc.* v. *Pennsylvania Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000). Because the Secretary's views of this case have changed in light of *Pegram*, and because this is the first opportunity to express those views since *Pegram*, the Secretary has a strong interest in participating in this stage of the proceeding.

ARGUMENT

IN LIGHT OF *PEGRAM*, IT IS UNCERTAIN IN THE PRESENT POSTURE OF THE CASE WHETHER USHC IS ENTITLED TO SUMMARY JUDGMENT ON PREEMPTION GROUNDS

A. *Under Pegram, an important element in the preemption inquiry is whether USHC made a "mixed" treatment and eligibility decision*

1. *General preemption principles.*

Section 514(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), provides

(with exceptions not herein relevant) that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any [ERISA-covered] employee benefit plan." The term "State laws" includes state common law. See 29 U.S.C. 1144(c)(1) (term includes "decisions" having the effect of law); *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 47-48 (1987). Thus, as this Court recognized, the negligence claim against United States HealthCare of Pennsylvania (USHC) in this case is preempted if it "relate[s] to" the ERISA plan through which Mr. Pappas received health maintenance organization (HMO) coverage. See *Pappas* v. *Asbel*, 555 Pa. 342, 345 n.1, 347 n.3, 724 A.2d 889, 890 n.1, 891 n.3 (1998), vacated, 120 S. Ct. 2686 (2000).

In determining whether ERISA preempts a state law, the Court should start with the presumption that Congress did not want to preempt a state's historic police powers in areas such as regulation of medical care, unless there is a clear and manifest intent to the contrary. *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 654-655, 661 (1995) A state law that has a "reference to" or "connection with" ERISA plans is preempted (unless too tenuous or remote); the requisite reference or connection is determined, however, not by the "unhelpful text" of Section 514(a)'s "relate[s] to" language but by ERISA's objectives. *Id.* at 656. Those objectives are:

> 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives

> among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'

Id. at 656-657 (citations omitted; Court's alterations).

Thus, Section 514(a) preempts a state law that regulates core ERISA functions, such as one that "mandate[s] employee benefit structures or their administration." *Travelers*, 514 U.S. at 658. Additionally, Section 514(a) preempts "alternative enforcement mechanisms," *ibid.*, such as state-common law actions for improper processing of a claim for benefits. *Pilot Life*, 481 U.S. at 52-57 (such claims are preempted because, among other things, they conflict with Congressional intent that the civil enforcement scheme in Section 502(a) of ERISA; 29 U.S.C. 1132(a), be exclusive).[2] Moreover, apart from Section 514(a), under ordinary conflict preemption analysis, ERISA preempts any state law that directly conflicts with ERISA provisions (*i.e.*, that cannot be accomplished without violating ERISA) or frustrates its purposes. *Boggs* v. *Boggs*, 520 U.S. 833, 841 (1997); see also, *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 533 (5th Cir.), on reh'g, 220 F.3d 641 (5th Cir. 2000).

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2. The government has questioned whether *Pilot Life*'s reliance on Section 502(a) of ERISA should apply to state laws that are exempted from ERISA preemption under 29 U.S.C. 1144(b)(2) because they regulate insurance. See *UNUM Life Ins. Co.* v. *Ward*, 526 U.S. 358, 376 n.7 (1999). Because there is no claim that the state negligence law at issue in this case regulates insurance per se, *Pilot Life*'s construction of Section 502(a) is applicable.

2. *Prior proceedings in this case.*

In its 1998 decision, this Court held broadly that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," and therefore are not preempted. *Pappas*, 555 Pa. at 351, 724 A.2d at 893. The Court declined to follow the reasoning of federal courts of appeals holding that certain claims against HMOs are preempted. *Id.* at 351 n.5, 724 A.2d at 893 n.5. See also, *e.g.*, *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1, 5-7 (1st Cir. 1999) (finding preemption under a *Travelers* analysis); *Parrino* v. *FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.) (same), cert. denied, 525 U.S. 1001 (1998).

In recommending that USHC's certiorari petition should be granted, the government argued that this Court's 1998 decision was overbroad. Fundamentally, the government argued, the decision failed to distinguish between USHC's role as a medical care provider and its role as the administrator of an ERISA plan. *United States Healthcare* v. *Pennsylvania Hosp. Ins. Co.*, No. 88-1836 (U.S.), Br. for the United States as Amicus Curiae 6-14 (*USHC*, U.S. Amicus Br.).[3] The government argued that when an HMO provides medical services, it is subject to suit under state law for negligence in performing its medical duties, but that ERISA generally preempts state law challenges to an HMO's actions in making benefits determinations in its role as a plan administrator. *Id.* at 10-11. Believing that a plan coverage decision is plan administration even when medical

3. Because the parties have attached copies of the United States' briefs in *USHC* and *Pegram* to their supplemental filings, we do not attach additional copies here.

judgment is "an adjunct" to it, *id.* at 11, the government stated that on "undisputed" but limited facts of record in this case, this Court did not suggest that USHC "exercised any medical judgment at all," *id.* at 12, and that the state negligence action "necessarily" challenged a benefits determination by USHC. *Id.* at 13; see also *id.* at 15 (arguing that the 1998 decision conflicted with *Pilot Life*). The government suggested that the United States Supreme Court should grant USHC's certiorari petition and either set the case for briefing or vacate this Court's 1998 decision and remand for reconsideration in light of *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000), which had not yet been decided.[4]

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4. The government argued that, if the United States Supreme Court agreed with the physician-petitioner in *Pegram* that the intended "benefit" from an HMO is simply membership in the HMO, rather than provision of medical benefits, then the conduct of USHC would not involve a claim for "benefits" under an ERISA plan and would therefore likely not be preempted. *USHC*, U.S. Amicus Br. 19. (The United States Supreme Court did not adopt that categorical argument that the actions of an HMO never constitute plan administration.) The government also argued that if the Court held in *Pegram* that some of the claims in that case involved "administration" and are governed by ERISA, that would effectively hold or strongly imply that claims such as the negligence action against USHC were preempted. *Ibid.* Consistent with that argument, the government argued in *Pegram* that, to the extent the physician incentives at issue in that case constituted plan administration, they involved fiduciary conduct subject to ERISA. The Court, however, held that the HMO's "mixed" treatment and eligibility decisions were not subject to ERISA's fiduciary standards. See *Pegram*, 120 S. Ct. at 2151-2158.

3. *The Pegram decision and its effect on this case.*

In *Pegram*, the United States Supreme Court addressed the scope of fiduciary liability under ERISA. In the course of doing so, it established two overlapping principles that are relevant to this Court's disposition of the instant case.

First, *Pegram* agreed with the government that an HMO may act both as plan administrator and as a medical care provider. *Pegram*, 120 S. Ct. at 2147. In particular, the Court ascribed different roles to HMOs depending on whether they are delivering medical care, making coverage determinations as insurers do, or administering an ERISA plan. See *id.* at 2149, 2151. The Court explained that the term "plan" means "a scheme decided upon in advance," and here "comprises a set of rules that define the rights of a beneficiary and provide for their enforcement." *Id.* at 2151. Thus, while documents setting up the HMO are not an ERISA plan, "the agreement between an HMO and an employer who pays the premiums may, as here, provide elements of a plan by setting out the rules under which beneficiaries will be entitled to care." *Ibid.* The Court reasoned that an HMO may be an ERISA fiduciary "if it administers the plan." *Ibid.*

In discussing an HMO's roles as a medical care provider, the Court distinguished HMOs from traditional fee-for-service provider. In particular, the Court reasoned that an HMO, unlike the fee-for-service providers, agrees to provide specified health care, if needed, for a fixed fee and thus assumes the financial risk that the cost of treatment will exceed the fees received. *Pegram*, 120 S. Ct. at 2149. The financial incentives in an HMO system are thus to provide

less care, not more. *Ibid.* No HMO organization, according to the Court, could survive without some incentive connecting physician reward with treatment rationing. *Id.* at 2150.

The second principle that derives from *Pegram* is that ERISA does not preempt state law that applies to the HMO's medical treatment decisions, even when they are what the Court described as "mixed" treatment and eligibility decisions. The Court reasoned that an HMO, acting through its physicians, makes three kinds of decisions: treatment decisions, pure eligibility decisions, and mixed treatment and eligibility decisions. 120 S. Ct. at 2153-2155. The Court described "treatment decisions" as "choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* at 2154. "Pure eligibility" decisions are ones that "turn on the plan's coverage of a particular condition or medical procedure for its treatment." *Ibid.* "Mixed" treatment and eligibility decisions arise when treatment and pure eligibility decisions "are . . . practically inextricable from one another." *Ibid.* In the Court's view, "many and possibly most coverage" questions are likely to require "mixed" treatment and coverage decisions because they are not "simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)." *Ibid.* A coverage question that requires medical judgments about "when-and-how" to provide

treatment gives rise to a "mixed" medical-treatment and eligibility decision. *Ibid.*[5]

Pegram holds that "treatment" decisions and "mixed" treatment and eligibility decisions by physician employees of an HMO are governed by state malpractice standards and not by ERISA fiduciary standards. 120 S. Ct. at 2147, 2157-2158. Indeed, the Court found no "value" in recognizing an ERISA action because such an action "would simply apply the law already available in state courts and federal diversity actions today." *Id.* at 2158. *Pegram* thus rejected the government's understanding, expressed in its briefs in *USHC* and in *Pegram* and based on the pre-*Pegram* case law from various federal courts, that an HMO's coverage decision is plan administration that is subject to ERISA's fiduciary standards even when it involves medical judgment about how to treat a patient, and regardless of whether it is made before or after treatment is provided.[6]

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5. In other words, generally speaking, an HMO is wearing its medical provider hat when making treatment decisions, its plan administrator hat when making pure eligibility decisions, and both hats when making "mixed" decisions.

6. The HMO in *Pegram* was owned by its physicians, who made "mixed" eligibility decisions in the course of treating patients. See 120 S. Ct. at 2147. HMOs such as USHC that contract with independent physicians to provide services make the same kind of decisions in the course of reviewing decisions by treating physicians. Because *Pegram*'s holding, that ERISA's fiduciary standards do not govern "mixed" treatment and eligibility decisions by HMO physicians, turns on the nature of the decision, and not on the structure of the HMO making the decision, the logic of *Pegram*

(Cont'd)

We believe that the United States Supreme Court, by vacating and remanding this Court's decision for reconsideration in light of *Pegram*, has requested this Court to consider and apply the two principles discussed above. We conclude that, following this approach, the Court should hold that USHC may have made a "mixed" treatment and eligibility decision and, if it did, ERISA does not preempt a state negligence action challenging the decision.[7] We also conclude that the case should be remanded for further development of the facts necessary to address the preemption question.

B. *The negligence action in this case is not preempted to the extent that it challenges a "mixed" medical-treatment and eligibility decision*

1. *State law governing "mixed" decisions is generally not preempted.*

As discussed above, *Travelers* requires a court to begin with the presumption that ERISA does not preempt state law

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(Cont'd)
applies to this case. See *id.* at 2155 ("Congress did not intend [the HMO in that case] *or any other HMO* to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians") (emphasis added).

7. Different considerations may apply when an HMO, or other managed care entity, uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid. Those are the sorts of decisions that insurance companies routinely make in determining whether payment should be made under a fee-for-service ERISA plan.

actions in the field of health care. Rather, as *Pegram* confirms, a "clear manifestation of congressional purpose" is necessary for preemption in that area of traditional state concern and authority. *Pegram*, 120 S. Ct. at 2158.

There is no such manifestation of preemptive intent with respect to the general category of treatment decisions that are intertwined with eligibility determinations by an HMO, *i.e.*, coverage decisions that involve or implicate medical judgments (and thus involve or implicate the HMO's role as a health care provider). ERISA's overriding purpose is to protect the interests of participants and beneficiaries, see 29 U.S.C. 1001(b), and Section 514(a) was enacted to "round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29,197 (1974 (statement of Rep. Dent). Section 514 (a) will not round out any protection to participants if an HMO can escape responsibility as an ERISA fiduciary for its "mixed eligibility decisions," as *Pegram* holds, and also avoid state malpractice law.[8] Instead, there will be a gap in protection as courts have recognized. See, *e.g.*, *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1333 (5th Cir.), cert. denied, 506 U.S. 1033 (1992).

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8. Section 514 (a), as enacted, was drafted in conference, and there is little legislative history explaining how far it extends. See *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98-100 (1983). The primary sponsors in the Senate understood that ERISA would not preempt local bar associations' regulation of attorneys as attorneys, although it would preempt attempts to regulate the form and content of pre-paid legal services plans. 120 Cong. Rec. at 29,949 (statements of Sen. Javits and Sen. Williams). Legislators therefore appear to have been concerned with protecting the structure, form, and content of plans, not with relieving professionals of their liability for malpractice.

Moreover, allowing state law challenges to medical judgments made in the context of an HMO's mixed treatment and eligibility decisions should not defeat ERISA's goal of ensuring that plans and plan sponsors would be subject to a uniform body of benefits law and not face the administrative and financial burdens of complying with conflicting state laws. See *Travelers*, 514 U.S. at 656. A "mixed" treatment and eligibility decision involves "when-and-how" questions of treatment and coverage that require the application of medical standards to the facts of particular cases. See *Pegram*, 120 S. Ct. at 2154-2155. In general, state tort law "would not threaten uniformity because the determination is an individualized decision that dictates nothing regarding the treatment to be afforded in the next individualized case." Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Hous. L. Rev. 985, 1058 (1998); see also *id.* at 1064 (criticizing federal appellate decisions holding that ERISA preempts state actions challenging HMO utilization review decisions because "UR involves the individualized application of a standard to particular clinical symptoms"). We see no reason why this general rule against preemption of "mixed" eligibility and treatment decisions should not apply in the circumstances of this case.[9]

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9. Although *Pilot Life*, 481 U.S. at 48-57, holds that ERISA preempts state law actions alleging that an insurer had improperly processed a claim for disability benefits, the disability claim at issue in *Pilot Life* did not involve a claim for medical treatment. See *Black's Law Dictionary* 804 (7th ed. 1999) (defining "[d]isability insurance" as "[c]overage purchased to protect a person from a loss of income during a period of incapacity for work"). Accordingly, the reasoning in *Pegram*, rather than *Pilot Life*, is applicable in this case.

2. *The claim at issue may involve a "mixed" treatment and eligibility decision*

The negligence action in this case concerns USHC's response to a May 1991 medical emergency involving Basile Pappas, a participant in USHC's HMO. Mr. Pappas was in the emergency room at Haverford Community Hospital, complaining of paralysis and numbness in his extremities. *Pappas*, 555 Pa. at 344, 724 A.2d at 890. The emergency room physician, Dr. Dickter, diagnosed a probable epidural abscess pressing on Mr. Pappas's spine, requiring immediate surgery. *Ibid.* Dr. Dickter arranged to transfer Pappas to a hospital with a spinal cord trauma unit that was able to commit to his immediate admission, but the ambulance service that was to transfer Pappas told Dr. Dickter that USHC would not authorize transfer to that hospital. *Id.* at 344-345, 724 A.2d at 890.

Dr. Dickter called USHC to explain that the situation was a neurological emergency. R 67a; see *Pappas* v. *Asbel*, 450 Pa. Super. 162, 166, 675 A.2d 711, 713 (1996), aff'd, 555 Pa. 342, 724 A.2d. 889 (1998), vacated, 120 S. Ct. 2686 (2000). A USHC representative reportedly consulted with a USHC doctor and, fifteen minutes later, another USHC representative called back to confirm that USHC would not authorize the transfer because the transferee hospital was not a USHC participating hospital. R 67a-68a; *Pappas*, 450 Pa. Super. at 166, 675 A.2d at 713. The representative did state that USHC would cover treatment at any of three other participating hospitals, however. R 67a-68a; *Pappas*, 555 Pa. at 344-345, 724 A.2d at 890. In fact, under the terms of the plan, the HMO did not require pre-certification for

emergency care or restrict where such care could be provided. R 156a, 158a.[10]

USHC's alleged negligence thus arises from its involvement in the decision on how to treat a medical emergency. In particular, the negligence claim brought by appellees incorporates the allegations by Mr. Pappas that Haverford damaged his spine by delaying inordinately his transfer, alleges further that USHC refused to authorize the transfer that Haverford selected, and asserts that if Mr. and Mrs. Pappas prevailed against Haverford, USHC would be liable to Haverford for that award. R 12a-13a, 19a.

As the government argued to the United States Supreme Court, there has been no determination that USHC exercised any medical judgment. *USHC*, U.S. Amicus Br. 12. Nevertheless, Dr. Dickter's attempt to explain that he had a neurological emergency, and the involvement of a USHC physician in USHC's decision, suggest that USHC's transfer decision may have involved some exercise of medical judgment as to whether an emergency existed or, assuming

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10. The federal Health Maintenance Organization (HMO) Act similarly requires USHC to reimburse a member for expenses the member incurs for care outside its organization when it is "medically necessary and immediately required because of an unforeseen illness, injury, or condition." 42 U.S.C. 300e(b)(4); see also 42 C.F.R. 417-103(e)(1) (same); *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 352 (3d Cir.) (USHC is "a federally qualified health maintenance organization"), cert. denied, 516 U.S. 1009 (1995). Since 1996, Pennsylvania has required state-regulated HMOs and other organizations to pay for or provide medically necessary services due to a medical emergency. 40 Pa. Cons. Stat. §§ 3041, 3042 (West 1999).

an emergency existed, whether the non-affiliated hospital that Dr. Dickter recommended was as well-equipped as the HMO-affiliated hospitals to deal with the emergency. In either case, USHC would have made a mixed treatment and eligibility decision.[11] See *Pegram*, 120 S. Ct. at 2155 (such "mixed" questions include, among other things, doctors' conclusions about "making referrals to physicians and facilities other than [the HMO's]" and "the emergency character of a medical condition").

Because the case was decided on USHC's motion for summary judgment — and because it is possible that USHC made a "mixed" medical-treatment and eligibility decision such that a state-law medical malpractice or corporate negligence action challenging USHC's medical judgment would not be preempted for reasons discussed above — we suggest that the Court may wish to vacate the summary judgment in favor of USHC and remand the case for further proceedings on that issue in light of *Pegram*. See *Pappas*, 555 Pa. at 346, 724 A.2d at 891 (on summary judgment, "all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party").

Under *Pegram*, 120 S. Ct. at 2154, a "pure" eligibility decision is one that "turn[s] on the plan's coverage of a particular condition or medical procedure for its treatment," and decides a "yes-or-no" question, "like whether appendicitis is a covered condition (when there is no dispute

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11. Justice Nigro concluded that USHC's actions "constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Pappas*, 555 Pa. at 385, 724 A.2d at 894 (Nigro, J., concurring).

that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)." A state law action challenging a pure eligibility decision could raise preemption concerns because a pure eligibility decision interprets what the plan means, not just for one claimant but for all claimants with that condition. Allowing state law to govern questions that "turn on the plan's coverage," *ibid.*, could lead to state court decisions mandating coverage, contrary to the intent of the plan sponsor, and to different results in different states, depending on how state law applies to issues of plan interpretation. State laws that "mandate[ ] employee benefit structures or their administration" are preempted under United States Supreme Court precedents (unless saved as insurance regulation). See, *e.g.*, *Travelers*, 514 U.S. at 658.

In this case, USHC could arguably have made a "pure" eligibility decision if it simply misread its plan, contrary to the terms of the plan and its obligations under the federal HMO Act, see *supra*, p. 15 & note 10, to require that emergencies be handled only by hospitals affiliated with the HMO. If so, then it would be necessary to consider whether, notwithstanding ERISA's preemption clause, state regulation of medical care may extend (with respect to emergency treatment or more generally) to regulating an entity that undertakes to provide medical care but fails to do so, even in a context in which the HMO is making a "pure" eligibility decision.

We take no position on that issue here. In our view, there is insufficient information about both the nature of the legal claim that is being asserted in this case and the underlying

facts concerning USHC's conduct to allow a full exploration of that issue by this Court in the current posture of the case. We do not know, for example, whether any state-law duty that might be alleged even in the absence of any exercise of medical judgment by USHC arises from a "corporate negligence" theory or some other source. See *Pappas* v. *Asbel*, No. 0098 E.D. App. Dkt. 1996 (Pa.), Br. of American Med. Ass'n as Amicus Curiae 26-27 (discussing various theories of negligence).[12] Some courts have held that HMOs and their physicians have certain duties as medical care providers that may give rise to nonpreempted state law actions. See *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 163-164 (3d Cir. 1999) (Section 502(a) of ERISA does not preempt charge that HMO was negligent in adopting hospital utilization policies that discouraged certain hospital admissions; plaintiffs "seek recovery for decisions that [the HMO] made in providing and arranging medical services"), cert. denied, 120 S. Ct. 2687 (2000); *Nealy* v. *US Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1999) (claim that primary care physician negligently failed to submit a timely specialist referral form to an HMO for approval fell within the

12. See also *Thompson* v. *Nason Hosp.*, 527 Pa. 330, 339-340, 591 A.2d 703, 707 (1991) (applying "corporate negligence" doctrine to hospitals); *Shannon* v. *McNulty*, 718 A.2d 828, 831, 835-836 (Pa. Super. Ct. 1998) (extending doctrine to HMOs); *Jones* v. *Chicago HMO Ltd.*, 730 N.E.2d 1119, 1128-1129 (Ill. 2000) (same); *Thompson*, 527 Pa. at 340, 591 A.2d at 708 (one who undertakes to render services to another which he should recognize as necessary to protect the other's person may be subject to liability for physical harm resulting from his failure to exercise reasonable care in the undertaking); *McClellan* v. *Health Maintenance Org. of Pa.*, 413 Pa. Super. 128, 139-141, 604 A.2d 1053, 1059 (applying principle to HMO), allocatur denied, 532 Pa. 664, 616 A.2d 985 (1992).

traditional domain of state regulation of health care and was not preempted by ERISA); *USHC* U.S. Amicus Br. 14 n.9 (if Dr. Asbel, the primary care physician in this case, was a network provider, the Pappases could have alleged that USHC was vicariously liable for his malpractice or directly negligent in selecting him as a provider, but no such claims were made). Here, however, the question would be whether breach of any such state-law duty by an HMO is actionable when it occurs in connection with a "pure" eligibility decision in construing coverage under an ERISA plan. *Pegram* does not address that specific question.

For these reasons, we suggest that the Court remand the case for further development on what state law negligence claims are being alleged and for further development of the facts before addressing the preemption question. Cf. *Pegram*, 120 S. Ct. at 2153 (pleadings must "be parsed very carefully" to understand what acts are at issue) In particular, on remand, the Court of Common Pleas may make a factual finding whether USHC made a mixed medical-treatment and eligibility decision, in which event a state-law malpractice or other negligence action challenging the medical decision would not be preempted. If that court finds that USHC did not make a mixed medical-treatment and eligibility decision, the court could then consider whether USHC breached some other state-law duty that might be alleged under whatever facts are found and, if so, consider in the first instance whether any such state law duty is preempted by ERISA.

Appendix

CONCLUSION

The judgment of the Superior Court should be vacated and the case should be remanded for further proceedings as described herein.

Respectfully submitted.

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In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of Pennsylvania

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

The petition in this case argued that the decision below conflicts with decisions of numerous federal courts of appeals. Respondents do not attempt to argue otherwise. The existence of a split of relevant authority and the importance of the question presented are undisputed. Respondents no longer question this Court's jurisdiction, as they once did unsuccessfully. See Pet. 1 n.1. Respondents do not urge that the pendency of proposed legislation should forestall a grant of certiorari, and the fate (as well as the relevance) of the proposed legislation remains highly uncertain. See, *e.g.*, *Stage Set for Patients' Rights Conference; Chambers to Spar Over Liability Language*, 70 U.S.L.W. 2135 (Aug. 28, 2001).

Respondents do make a halfhearted effort to explain away one Third Circuit case, and they argue the merits extensively. None of respondents' arguments should dissuade this Court from granting certiorari.

1. The petition argued that the decision below conflicts most specifically with decisions of the Third and Fifth Circuits, rendered after *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), that construe *Pegram* not to overturn prior circuit law holding that state-law challenges to an HMO's administration of benefits under an ERISA-regulated plan are preempted, even if the administration-of-benefits determination may be characterized as a "mixed" decision that includes an element of medical judgment. Respondents ignore the relevant portion of the Fifth Circuit decision. As to the Third Circuit decision, *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266 (2001), respondents argue that it "facially conflicts impermissibly with * * * prior and binding Third Circuit panel decisions." Br. in Opp. 20. Yet, if respondents and the former Solicitor of Labor are right in their critical contention that *Pegram* radically narrowed the scope of ERISA preemption and called into question prior decisions holding that certain claims against HMOs *are* preempted, it is passing strange that the Third Circuit supposedly lurched in the *opposite* direction after *Pegram*.

Furthermore, respondents make no effort to explain why the distinctions Judge Sloviter, for a unanimous panel, drew between *Pryzbowski* and the prior decisions are incorrect. That is a particularly odd omission considering that Judge Sloviter was

the author of one of those prior decisions, *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (1999), cert. denied, 530 U.S. 1242 (2000). The Third Circuit – unlike respondents and the Supreme Court of Pennsylvania – understands that a distinction must be drawn between cases in which what the plaintiffs attack is "essentially a medical determination that could be subject to a state-law malpractice action" (*Pryzbowski*, 245 F.3d at 272, summarizing the holding of *In re U.S. Healthcare*) and those in which the plaintiffs attack "the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists," which "fall[s] within the realm of the administration of benefits" (*id.* at 273). See also 245 F.3d at 274-275.

Curiously, respondents suggest that this Court "could distinguish *Pryzbowski*, as involving a delay in making a benefit determination, and directly related to plan administration, as opposed to a negligent medical judgment concerning which independent provider was capable of supplying the care needed within the time it was needed." Br. In Opp. 3. *Pryzbowski* and the present case are identical in that both involve allegations that medical considerations should have overridden, but did not override, the HMO's preference for in-network providers, resulting in delay that allegedly harmed the subscriber. Thus, either *Pryzbowski* is right in holding that such allegations challenge benefits administration and are preempted by ERISA, or the decision below is right in holding that they somehow escape preemption. Both courts cannot possibly be right, and therefore *Pryzbowski* cannot be distinguished on the ground respondents propose.

2. Rather than make a serious effort to reconcile the decision below with any of the decisions – pre- and post-*Travelers*, pre- and post-*Pegram* – cited in the petition, respondents have chosen to devote almost all of their 22-page brief in opposition (with 21-page attachment) to arguing the merits. Although the merits are not the major factor bearing on the suitability of this case for a grant of certiorari, we will reply in kind.

a. We showed in the petition that, because the third-party complaint in this case challenged petitioner's decision about whether Mr. Pappas was eligible for ERISA plan benefits, the complaint directly "relate[s] to" such a plan, 29 U.S.C.

§ 1144(a), and impermissibly provides an alternative enforcement mechanism to the carefully drawn ERISA remedies in 29 U.S.C. § 1132(a). The state-law claims are therefore preempted. The Pennsylvania Supreme Court's decision in *Pappas I*, reaffirmed in *Pappas II*, that the claims survived – indeed, that *any and all* negligence actions against health maintenance organizations are outside ERISA's preemptive scope – conflicts with this Court's decisions in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985); and *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983). See Pet. 12-16.

Respondents answer by accusing petitioner (and, by extension, all HMOs) of seeking "a declaration of immunity from negligence" (Br. in Opp. 16) and of hoping to "obliterate[] a traditional state field of law" (Br. in Opp. 17) and "eradicate state health care malpractice actions against service providers"(*ibid.*). But our position does not sweep nearly so broadly. If, for example, the alleged basis for liability of the HMO is that its own personnel committed medical malpractice in the course of treating a subscriber, there is no reason why the malpractice claims need implicate plan administration and no reason why ERISA should preempt them. See 98-1836 U.S. Br. 10, *quoted in* 01-200 Pet. 7. Those were the facts of *Pegram* v. *Herdrich*, in which the malpractice claims resulted in a judgment for the plaintiff and were not at issue in this Court. See 530 U.S. at 217. But trying to hold an HMO liable because it will not *pay for* out-of-network services is a different proposition entirely.

In this regard, respondents' reformulation of the question presented is not at all faithful to the record or to petitioner's arguments. According to respondents, this case involves "the negligence of HMO-employed health care services professionals in the performance of their *duties to provide or to arrange for* appropriate medical care for the beneficiaries of ERISA plans." Br. in Opp. i (emphasis added). But no employee of petitioner provided or had a duty to provide medical care for Mr. Pappas; petitioner contracted with third parties who provided medical care. Indeed, it is *respondents* who stand in the shoes of the medical providers who were allegedly negligent in this case and who have settled with the Pappases. Nor is it accurate to blur the distinction between arranging for medical care and paying for medical care. See *Danca* v. *Private Health Care Sys., Inc.*,

185 F.3d 1, 6 n.6 (1st Cir. 1999) (explaining that the benefits under an ERISA health plan are "the monetary payments for medical services, not the services themselves"), *quoted in* 98-1836 U.S. Br. 9-10. Nor, finally, does the record support the proposition that any "health care service professionals" employed by petitioner did anything more than determine what hospitals are in petitioner's network. See Pet. 11 n.3. Until it became convenient in *Pappas II* to assert (without record support) that this case involves an exercise of medical judgment, the Pennsylvania courts themselves emphatically read the record the opposite way. Pet. App. 50a ("the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations").

It is the decisions of the Pennsylvania Supreme Court – not petitioner's modest position – that would have a devastating and radical effect, harming HMOs by permitting flank attacks on managed-care providers, through state tort actions, in the face of the "congressional policy of promoting HMOs." *Pryzbowski*, 245 F.3d at 275 (citing *Pegram* for the proposition that the Court "reject[ed] claims attacking financial incentives behind HMO structure").

b. Atmospherics aside, respondents offer two main arguments on the merits. First, they say that *Pilot Life*, *Metropolitan Life*, and *Shaw* are no longer good law in view of what they call the "shift" in this Court's ERISA preemption jurisprudence. Br. in Opp. 10 (citing *New York State Conf. of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997)). Given the shift in ERISA paradigms, respondents say, *Pappas I* and *II* pose no conflict with this Court's governing decisions or those decisions of the federal courts of appeals that are faithful to them. Second, respondents say that *Pegram* v. *Herdrich* – which in fact concerned ERISA fiduciary status – actually endorsed a new rule concerning ERISA preemption, that "mixed" decisions of treatment and eligibility are not preempted. Because, they say, the decision at issue here was not, in fact, administrative, but rather "mixed," a challenge to it survives "consistent" (Br. in Opp. 13) with *Pegram*. Neither of those arguments has merit.

i. Respondents' principal argument is that the Pennsylvania Supreme Court's decision, though (respondents admit) inconsistent with *Pilot Life* and *Metropolitan Life* (and *Shaw*), is consistent with the Court's new-and-improved ERISA jurisprudence reflected in *Travelers* and *Dillingham* (and *DeBuono*). See Br. in Opp. 10-13. According to respondents, the "earlier," "original approach" of *Pilot Life*, *Metropolitan Life*, and *Shaw* (Br. in Opp. 10) "emphasized the general nature of the ERISA preemption clause's 'relates to' phrase" (*ibid.*). "In contrast," respondents argue, the "later approach" that this Court supposedly adopted in *Travelers*, *Dillingham*, and *DeBuono* (Br. in Opp. 11), along with the "restrictive approach" that the Court took in *Pegram* (Br. in Opp. 12), make it clear that *Pilot Life*, *Metropolitan Life*, and *Shaw* – though not, respondents acknowledge, in fact overruled (Br. in Opp. 11-12) – are effectively dead letters. See also Pet. App. 37a (Pennsylvania Supreme Court majority terming *Pilot Life*, *Metropolitan Life*, and *Shaw* "superannuated" and declining to follow them).

Respondents – like the Pennsylvania Supreme Court – have misread the law. As we noted in the petition (at 12-17), the Court has taken pains in its recent decisions to express, as in *Travelers*, "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. In *DeBuono*, similarly, the Court noted that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' * * * ERISA benefit plans." *Id.* at 813; see also *Dillingham*, 519 U.S. at 335 (Scalia, J., concurring) (noting that the majority opinion "does obeisance to all our prior cases"); *UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999).

In further support of their contention that *Pilot Life*, *Metropolitan Life*, and *Shaw* have been silently overruled, respondents point to the Court's decision in *Pegram*. Br. in Opp. 12. It is true, as respondents note, that the former Solicitor of Labor (whom respondents persistently but mistakenly refer to as "the Solicitor General") wrote in an amicus brief filed in *Pappas II* that *Pegram* had changed the government's views on the propriety of summary judgment here. In *Pappas I* the government had filed a brief in this Court stating that "the

blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life*," 98-1836 U.S. Br. 6; in *Pappas II* the government suggested that the claims "may have been preempted in light of *Pegram*, Br. in Opp. App. 4a, 9a-12a; see Pet. 8-9 (discussing government's remand brief).

The government jumped the gun: the *Pegram* opinion itself *reserved decision* on how claims for denials of benefits "interact[]" with "state law causes of action." 530 U.S. at 229 n.9. And the government's qualified *volte face* has found no sympathizers aside from the Pennsylvania Supreme Court. Respondents have cited no case, and we have found none, in which another court has read *Pegram* – which dealt with ERISA fiduciary status – to have radically altered the law governing the distinct question of ERISA preemption. In fact, courts have said just the opposite: that when it comes to preemption, *Pegram* changed nothing. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 220 F.3d 641, 643 (5th Cir.), denying rehearing to 215 F.3d 526 (5th Cir. 2000), petition for cert. pending, No. 00-665; *Tran* v. *Kaiser Foundation Health Plan of Texas*, 2001 WL 1082418 (N.D.Tex. Sept. 7, 2001); *Howard* v. *Coventry Health Care of Iowa, Inc.*, 2001 WL 1013610 (S.D. Iowa July 20, 2001); Pet. 22-23 & n.7 (collecting additional cases).*

Aside from questioning the vitality of *Pilot Life*, *Metropolitan Life*, and *Shaw*, respondents make no attempt to refute our showing that the expansive holding of *Pappas I*, which was reaffirmed in *Pappas II*, conflicts with those decisions. Instead,

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* Respondents, the former Solicitor of Labor, and some commentators may be fond of invoking *Pegram* as a decision expanding the field of state law not preempted by ERISA, but not a single judge anywhere appears to have agreed. The only jurists who might be said to have agreed with any part of that reading of *Pegram* are the justices of the Pennsylvania Supreme Court in this case, yet that court had already – in *Pappas I* – read ERISA to preempt *no* "negligence claims against a health maintenance organization" (Pet. App. 39a), thus making it impossible for the field of non-preempted state law to get any broader. In *Pappas II*, those justices "adhere[d] to [their] original opinion" (Pet. App. 2a) yet simultaneously recognized that *Pegram*, if anything, *narrowed* their earlier holding by forcing them to labor to find a way (unsupported by the law or by the record) to call this case one involving a "mixed eligibility and treatment decision" (Pet. App. 13a).

respondents say that that broad rationale can be teased out of the Pennsylvania Supreme Court's opinions only through a "selective reading" of what was "arguably dicta" in *Pappas I* (Br. in Opp. 2 & n.1) and, in any event, was not even at issue in *Pappas II*. Both assertions are wrong. The Pennsylvania Supreme Court *held* in *Pappas I* that "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." Pet. App. 39a. The sentences in the opinion that follow (see *ibid.*) do not "clarify[]" (Br. in Opp. 2 n.1) that holding, or qualify it, or in any other way transform that sweeping holding into "dicta," arguable or otherwise. In *Pappas II*, moreover, the Pennsylvania Supreme Court expressly "adhere[d] to [its] original opinion and order" and "confirm[ed] [its] original disposition," Pet. App. 2a, 14a. The original disposition, and the subsequent one, cannot be reconciled with *Pilot Life*, *Metropolitan Life*, and *Shaw*, and no decision of this Court gave the court below authority to disregard those decisions. See *United States* v. *Hatter*, 121 S. Ct. 1782, 1790 (2001) ("'it is this Court's prerogative alone to overrule one of its own precedents'") (quoting *State Oil Co.* v. *Khan*, 522 U.S. 3, 20 (1997)).

ii. Respondents also argue that the alternative holding of *Pappas II* – that the decisions at issue in this case were "mixed" ones of treatment and eligibility, rather than eligibility alone – is consistent with *Pegram*. As we have explained, this argument depends on the assumption that *Pegram* is the binding decision concerning ERISA preemption. But it is not.

Aside from this error of law, respondents point to certain distinctions, but the distinctions make no difference. Respondents note that "[n]either the ERISA plan nor the employer" is a party "to this case." Br. in Opp. 13. This is true, but irrelevant. Whom the Pappases, or third parties, decided to sue has no bearing on the nature of the claims that were brought: claims attacking petitioner's decision whether Mr. Pappas was entitled to certain benefits under his health plan. Our point here – that the state-law claims that were brought challenged an administrative decision concerning coverage, and thus "relate to" the administration of an ERISA benefit plan and provide an alternative enforcement mechanism – is also true without regard to whether petitioner was the "administrator" of Mr. Pappas's plan, which is respondents' second distinction (Br. in Opp. 14) and as irrelevant as the first. "Administrator" is a defined term

in ERISA that may be important for some purposes, but it is not a term used in Section 502(a) or in Section 514, and the technical 29 U.S.C. § 1102(16)(a) definition of "administrator" (as opposed to the distinction between plan administration and direct delivery of medical services) does not play a substantive role in any of the preemption cases on which petitioner or respondents rely. Respondents then maintain that "the claim in this case does not directly implicate a provision of the employer's ERISA plan." Br. in Opp. 14. Again, it is unclear why respondents think their distinction matters to the analysis, but in any event the Solicitor General correctly explained to this Court in 1999 that "[t]he ERISA plan in this case was the arrangement by which The Charming Shoppes * * * purchas[ed] memberships in petitioner's HMO" and "[t]he intended benefit was coverage for the specific kinds of medical care specified in Group Master Contract between petitioner and The Charming Shoppes." 98-1936 U.S. Br. 9, citing Pa. Super. Ct. App. 158a. It is therefore impossible to understand the relationship between petitioner and Mr. Pappas, and accordingly impossible to understand whether petitioners' benefit determination might have been negligent, without reference to plan documents. Respondents' "argument misses the point, which is that * * * there simply is *no* cause of action if there is no plan." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 140 (1990).

More significantly, according to respondents, the facts "suggest that the ultimate decision by the HMO's Medical Director was completely or predominately [*sic*] a medical determination." Br. in Opp. 4; see also *id.* at 15 (suggesting, with absolutely no support, that petitioner's decision had "medical treatment aspects"). The facts "suggest" no such thing. Respondents cite the deposition testimony of Dr. Steven Dickter, Mr. Pappas's treating physician, and a typed version of notes taken by an emergency medical technician (EMT) who treated Mr. Pappas at Mr. Pappas's home. Br. in Opp. 4. Dr. Dickter, however, was not employed by petitioner; in any event, he spoke *only* with petitioner's administrative (not medical) personnel. See Pet. 3 (citing Pa. Super. Ct. App. 67a-68a (deposition of Dr. Dickter at 47-52)). These administrative personnel, and not Dr. Leibowitz (petitioner's Medical Director), were the "HMO representatives" to which respondents refer. Br. in Opp. 4. The EMT was not employed by

petitioner either; he never had any contact with, and his notes make no mention of, petitioner or anyone associated with it. Pa. Super. Ct. App. 92a. *Nothing* in the record supports respondents' claim that the decision where to transfer Mr. Pappas had medical aspects at all. The decision at issue was whether Mr. Pappas's health plan would cover treatment at an out-of-network hospital – whether, that is, Mr. Pappas was or was not entitled to certain plan benefits. As courts have held on virtually identical facts, such a determination is administrative. See *Pryzbowski*, 245 F.3d at 274-275; see also *Calad* v. *Cigna Healthcare of Texas, Inc.*, No. 300-CV-2693-H, 2001 WL 705776 (N.D. Tex. June 21, 2001) ("claims arising from a delay or denial of benefits are ERISA-preempted"); Pet. 22 n.7 (citing other cases).

And suppose that the decision where to transfer Mr. Pappas was (in the formulation this Court used, outside the preemption context, in *Pegram*) a "mixed" one of treatment and eligibility, and thus, under *Pappas II*'s alternative rationale, not preempted. If so, such a result would conflict with the Fifth Circuit's decision in *Corporate Health Ins.*, where the court noted that "[w]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 220 F.3d at 643. It would also conflict with the Third Circuit's decision in *Pryzbowski* (not to mention the numerous district court decisions cited in the petition at 22 n.7). In fact, respondents themselves acknowledge, albeit grudgingly, that the "analysis and decision of the Third Circuit in *Pryzbowski* could be read to conflict with the analysis and decision of the Pennsylvania Supreme Court in *Pappas II*." Br. in Opp. 20.

The cases do conflict, and the Third Circuit got it right. As we explained in the petition (at 22-23), the Third Circuit rightly read *Pegram* as having been informed by Congress's determination to reject state-law assaults on the business justifications for HMOs. See 245 F.3d at 275 (noting that in *Pegram* the Court "reject[ed] claims attacking financial incentives behind HMO structure, in light of [the] congressional policy of promoting HMOs"). Endorsing negligence claims such as the one in *Pryzbowski*, that an HMO had wrongly delayed or denied benefits, "would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network

specialists over out-of-network specialists)," 245 F.3d at 274-275 – precisely the legal challenges that Congress has deemed unwise (and hence unlawful). As a result, the Third Circuit held, even if a decision could be viewed as including "mixed" considerations of treatment and eligibility, a state-law challenge to such a decision is preempted. This Court should review the Pennsylvania Supreme Court's contrary holding.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.,

Petitioner,

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PENNSYLVANIA HOSPITAL INSURANCE COMPANY, and THE COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF PENNSYLVANIA, EASTERN DISTRICT

SUPPLEMENTAL BRIEF FOR RESPONDENTS

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INTRODUCTION

Petitioner's supplemental brief of November 19, 2001 calls the Court's attention to a footnote in the Brief for the United States as Amicus Curiae in *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021, a case which focuses on an HMO's challenge to a state independent review statute. Petitioner recognizes that *Rush Prudential* and this case involve "analytically different" questions (Supplemental Brief for Petitioner, p. 6). Nevertheless, petitioner asserts that footnote 3 of the government's amicus brief in *Rush Prudential* is "critical" to its pending petition for writ of certiorari (*Id.*, p. 3), because, in the petitioner's view, that footnote "disavows" the brief that the Secretary of Labor filed with the Pennsylvania Supreme Court in *Pappas v. Asbel*, 768 A.2d 1069 (2001) (*Pappas II*) (*Id.*, p. 1, 3, 4). Putting its own spin on that footnote and on this case, petitioner's supplemental brief argues that the Pennsylvania Supreme Court "got it wrong." (*Id.*, p. 1, 3, 4).

Next, surmising that "[t]he Court's inaction on this case following the October 26 Conference almost certainly indicates that the case is being held pending the disposition of *Rush Prudential*," (Supplemental Brief for Petitioner, p. 4), petitioner's supplemental brief "urges" the Court to relist this case "for either the November 30 Conference or a Conference in December, and to grant certiorari at that time so that the case may be briefed, argued, and decided this Term" (*Id.*, p. 1, 5). Petitioner reiterates its view that action by your Honorable Court is needed at least to resolve the conflict which the petitioner sees between *Pappas II* and *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001), and to persuade the Pennsylvania Supreme Court to "see the error of its ways" and to "abandon its idiosyncratic ways." (*Id.*, p. 6).

I. FOOTNOTE 3 IN THE GOVERNMENT'S *RUSH PRUDENTIAL* BRIEF DOES NOT UNDERMINE THE GOVERNMENT'S SUPPORT FOR, OR THE CORRECTNESS OF, THE DECISION OF THE PENNSYLVANIA SUPREME COURT IN *PAPPAS II*

In their Brief in Opposition to petitioner's petition for writ of certiorari from the Pennsylvania Supreme Court's decision in *Pappas II*, respondents referred to and included as an appendix the amicus brief filed by the Secretary of Labor in *Pappas II*. Respondents did so to dispel the petition's misimpression that *Pappas II* merely rubber-stamped its decision in *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) (*Pappas I*), inconsistently with your Honorable Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), and with the government's views of *Pappas I*. Contrary to the petition's assertions, the government's amicus brief in *Pappas II* demonstrated that *Pegram* changed the government's view of this case and that *Pappas II* correctly considered and applied *Pegram* pursuant to your Court's remand directive.

Petitioner's reply brief acknowledged that the Secretary of Labor's amicus brief in *Pappas II* stated that "*Pegram* had changed the government's views" (Reply Brief for Petitioner, p. 5). However, petitioner's reply brief asserted that the change was only from seeing a conflict between the "blanket non-preemption rule" of *Pappas I*, and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), to seeing that the claim in this case may have been *preempted* in light of *Pegram*. (*Id.*, p. 5-6; emphasis added). Petitioner's reply brief also asserted that the government "jumped the gun" on its analysis and application of *Pegram* in the context of this case. (*Id.*, p. 6)

In contrast to the petitioner's mischaracterization, the position that the government took in *Pappas II* was that, following the principles crystallized by *Pegram*, "the Court should hold that USHC may have made a 'mixed' treatment and eligibility decision and, if it did, *ERISA does not preempt*

a state negligence action challenging the decision." (Br. in Opp. App. 12a; emphasis added). Furthermore, the government did not "jump the gun," because your Honorable Court expressly remanded the case to the Pennsylvania Supreme Court for reconsideration in light of *Pegram*.

Now, in its supplemental brief, petitioner asserts that the government has "disavowed" the amicus brief in *Pappas II*. Significantly, however, neither the Secretary of Labor nor the Solicitor General has filed or sought to file a brief or any other communication with your Honorable Court in this case to "disavow" the position that the government took in *Pappas II*. If, as the petitioner's supplemental brief asserts, the government no longer adheres to that position, one would have expected the government to express that allegedly new position to your Honorable Court and to the parties directly in this case, rather than through a footnote in a brief that was filed in an analytically different case. Moreover, a proper analysis of exactly what the government said in footnote 3 of its amicus brief in *Rush Prudential* undermines the petitioner's assertion that the government used that footnote to disavow what it argued in *Pappas II*, and by implication, to disavow the decision made by the Supreme Court of Pennsylvania in *Pappas II*.

Although petitioner's supplemental brief regards footnote 3 of the government's amicus brief in *Rush Prudential* as "critical" to its pending petition for writ of certiorari (Supplemental Brief for Petitioner, p. 3), that brief does not present the full text of that footnote. The footnote states (00-1021 U.S. Br. 8-9):

> The Secretary of Labor addressed the import of *Pegram*[*v. Herdrich*, 530 U.S. 211 (2000)] in an amicus brief filed with the Pennsylvania Supreme Court in *Pappas v. Asbel*, 768 A.2d 1069 (2001), petition for cert. pending, No. 01-200, on remand from this Court, see *United States Healthcare Sys. Of Pa., Inc. v. Pennsylvania Hosp.*

> *Ins. Co.*, 530 U.S. 1241 (2000). In *Pappas*, an HMO employee — who was not a treating physician — refused to authorize out-of-network treatment for an HMO subscriber. The Secretary contended that " the logic of *Pegram* applie[d]" to that case. Sec'y of Labor Br. at 11 n.6. However, the Secretary also noted that "[d]ifferent considerations may apply when an HMO * * * uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid." *Id.* at 12 n. 7. In any event, for the reasons given in the text, regardless of whether the claim is made before or after treatment, the better view is that an HMO employee deciding a claim is an ERISA fiduciary.

Contrary to the dramatic assertions of the petitioner's supplemental brief, the plain text of that footnote hardly "disavows" the brief that the Secretary of Labor filed in *Pappas II*. To put it bluntly, but accurately, the footnote says no such thing. The plain text of footnote 3 only refers to two footnotes in the *Pappas II* brief. Reference is made first to footnote 6, in which the government stated,

> Because *Pegram*'s holding, that ERISA's fiduciary standards do not govern "mixed" treatment and eligibility decisions by HMO physicians, turns on the nature of the decision, and not on the structure of the HMO making the decision, the logic of *Pegram* applies to this case. See *id.* at 2155 ('Congress did not intend [the HMO in that case] *or any other HMO* to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians') (emphasis added).

Br. in Opp. App. 11a-12a. Footnote 3 does not express any change in that view. Preceded by the signal word "However," footnote 3 then addresses footnote 7 of the *Pappas II* brief, in which the government stated,

> Different considerations may apply when an HMO, or other managed care entity, uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid. Those are the sorts of decisions that insurance companies make in determining whether payment should be made under a fee-for-service ERISA plan.

Br. in Opp. App. 12a. Footnote 3 then adjusts that view on claims for payment for treatment by stating, "for the reasons given in the text, regardless of whether the claim is made before or after treatment, the better view is that an HMO employee deciding a claim is an ERISA fiduciary."

In addition to missing the point of clarification made in footnote 3, where the government changed only what it said about a claim for payment for treatment, not what it said about the tort claim for bodily injury or contribution damages involved in this case, the petitioner's supplemental brief misconstrues the context in which footnote 3 was written. That footnote was written for *Rush Prudential*, an "analytically different" case, because it deals with the statutorily imposed rules for binding independent review at the option of the claimant versus the sole discretion rules written by the HMO. *Rush Prudential* does not involve the type of tort claim involved in this case.

The government's amicus brief in *Rush Prudential* chose first to speak to whether or not the statute "relates to" ERISA. 00-1021 U.S. Br. 6-11. The "text" to which footnote 3 refers presents the government's explanation that *Pegram* does not alter the government's conclusion that the independent review statute "relates to" ERISA. *Id.*, p. 7-11. What the government appears to have perceived in its *Rush Prudential* brief is simply that *Pegram* should not be read to hold that pure benefit or eligibility determinations do not lose their ERISA fiduciary status every time they may be made by a doctor or may involve some medical consideration.

To that extent, the government's amicus brief in *Rush Prudential* is in harmony with what your Honorable Court's unanimous opinion stated in *Pegram*, that, in considering whether a case involves a claim that is subject to ERISA, the pertinent questions are the capacity in which the HMO employee acted and then the nature of the decision at issue. In particular, your Court first observed that "the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram*, *supra*, 530 U.S. at 226. Next, your Court directed,

> It will help to keep two sorts of arguably administrative acts in mind. Cf. *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995) (discussing dual medical/administrative roles of HMOs). What we will call pure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment. 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patent's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

Pegram, *supra*, 530 U.S. at 227-228.

Furthermore, as your Honorable Court pointed out, pure eligibility decisions include determinations such as "whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)," *Pegram*, *supra*, 530 U.S. at 228, or "such as whether a plan covers an undisputed case of appendicitis," and "rejecting a claim for no other reason than the HMO's financial condition." *Id.* at 229. Thus, if what the government means to say in its amicus brief in *Rush Prudential* is that such decisions remain pure eligibility decisions even though they are made by

an HMO-employed doctor or involve some medical consideration, the government's brief correctly applies *Pegram*.

The government's amicus brief in *Rush Prudential* is also consistent with your Honorable Court's unanimous pronouncements in *Pegram* to the extent that the brief recognizes that "treatment decisions" or "mixed eligibility and treatment decisions," as defined in *Pegram*, are not ERISA-protected fiduciary decisions when made by an HMO doctor even though that doctor has no traditional physician-patient relationship with the plan participant or beneficiary. Given the limited contour of the case in which the government filed that amicus brief, where the question deals with the procedures under which a payment dispute about an HMO's eligibility decisions can be resolved, the brief's emphasis on "treatment" leaves intact the government's position in *Pappas II*, because the issue is one that implicates a treatment decision made when no genuine question of coverage appears, and yet preserves the point that the government tries to make in *Rush Prudential*, that the statute "relates to" ERISA because it involves "fiduciary" decisions under *Pegram* or the statute at least involves regulation of "the claims resolution processes utilized by ERISA plans". 00-1021 U.S. Br. 10-11.

However, if what the government's amicus brief is meant to suggest is that *Pegram* should be read to restrict the non-fiduciary status of "medical necessity" determinations and similar decisions, such as, "physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition," *Pegram*, *supra*, 530 U.S. at 229-230, to those made only by HMO physicians who have a traditional doctor-patient relationship with the claimant, the government's suggestion runs afoul of what your Court explicitly said in *Pegram*: those decisions are at least "mixed eligibility and treatment decisions,"

Id. "We think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians," *Id.* at 231, and "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA," *Id.* at 237. Moreover, your Honorable Court never expressed that limiting distinction in *Pegram*, but rather spoke in terms applicable to all HMOs and their employees. *See* 530 U.S. at 231-232.

What petitioner sees as "crucial" to its petition in footnote 3 of the government's amicus brief in *Rush Prudential* actually undermines petitioner's position. The government has not disavowed the central position which it took in light of *Pegram* in the brief that it filed with the Pennsylvania Supreme Court in *Pappas II*. That position, which views the claim made against the petitioner in this case as a mixed eligibility and treatment decision that is not preempted by ERISA, remains officially unchanged.

II. DISPOSITION OF THE PETITION FOR WRIT OF CERTIORARI

Respondents decline to join with petitioner in the speculation expressed in Part 2 of its supplemental brief as to why no order issued about this case following your Honorable Court's conference on October 26, 2001. Although respondents anticipate that your Court will dispose of the pending petition for writ of certiorari, respondents also decline to join with petitioner in dictating when your Court should make its decision.

Despite the petitioner's chastisement of the respondents' discussion of the merits of this case (Supplemental Brief for Petitioner, p. 1; Reply Brief for Petitioner, p. 2), petitioner's supplemental brief also discusses the merits of the case in urging your Honorable Court to promptly list the case, to grant certiorari to resolve the conflict which the petitioner sees between *Pappas II* and *Pryzbowski*, *supra*, and to persuade the Pennsylvania Supreme Court to "see the error of its ways" and to "abandon its idiosyncratic ways." (*Id.*, p. 6).

Consideration of the merits or circumstances of a case plays an undeniably important role in your Honorable Court's disposition of a petition for writ of certiorari. That is why petitioner's supplemental brief asserts that the Pennsylvania Supreme Court "got it wrong" in *Pappas II* and rendered a decision which draws a line of conflict between the state courts which are obliged to or choose to follow *Pappas II* and the federal courts which are obliged to or choose to follow *Corcoran* and *Pryzbowski*. One cannot make — or refute — such assertions and discuss the "certworthiness" of a case without considering the merits and the circumstances of the case.

Respondents' Brief in Opposition delineated the reasons why the Pennsylvania Supreme Court got it right in *Pappas II*, and there is no need to reiterate those reasons in this brief. Suffice it to say, that the petitioner's supplemental brief, like its petition for writ of certiorari and its reply brief, overlook or attempt to obscure the undeniable fact that this case involves at least a mixed decision or a pure treatment decision as defined in *Pegram*. This is so, because the petitioner was obliged to cover and clearly stated that it would cover emergency care "any time, anywhere," "anywhere in the world," "24 hours a day, 7 days a week," and that "[w]hen a delay would be detrimental to your health, seek the nearest medical attention". Respondents' Pennsylvania Supreme Court Reproduced Record, p. 156a, 157a, 158a. In short, this case does not involve a pure benefits determination that is shielded by ERISA. Rather, it involves a determination which *Pegram* clearly places beyond the ERISA preemption shield that the petitioner seeks to raise to prevent its being held accountable in the type of common place tort-based medical malpractice action which your Honorable Court has always regarded as not having been displaced by ERISA. *See Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-655 (1995); *Pegram, supra*, 530 U.S. at 235.

In its reply brief, petitioner recognized that "[i]f, for example, the alleged basis for liability of the HMO is that its own personnel committed medical malpractice in the course of treating a subscriber, there is no reason why the malpractice claims need implicate plan administration and no reason why ERISA should preempt them." (Reply Brief for Petitioner, p. 3). Petitioner's belief that respondents in this case are "trying to hold an HMO liable because it will not *pay for* out-of-network services" (*Id.*, emphasis in original) notwithstanding, the claim in this case is that petitioner committed medical malpractice by directing and delaying appropriate treatment. Thus, as stated in their brief in opposition, respondents respectfully suggest that your Honorable Court deny the petition for writ of certiorari.

CONCLUSION

For the foregoing reasons and those advanced in their brief in opposition, respondents respectfully ask that your Honorable Court deny the petition for writ of certiorari. Petitioner's insistence that *Pappas II* presents a conflict with *Pryzbowski* and that your Honorable Court should act swiftly rekindles the respondents' alternative suggestion that your Honorable Court grant the petition for writ of certiorari, summarily affirm *Pappas II* in light of *Pegram*, and note its disapproval of *Pryzbowski* and the other cases which petitioner asserts are in conflict with *Pappas II*.[1]

---

1. Petitioner's assertion that *Pappas II* conflicts with *Pryzbowski* makes *Pryzbowski* difficult to reconcile with *Pegram* and with the prior decisions of the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), and *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir. 2000). Courts in that circuit could decline to follow *Pryzbowski* on the ground that *Pryzbowski* conflicts with *Pegram*, *Mennan Co. v. Atlantic Mutual Ins. Co.*, 147 F.2d 287, 294 (3d Cir. 1998), or is "without effect," because it is inconsistent with the earlier panel decisions, *Pfieffer v. School Bd.*, 897 F.2d 779, 781 (3d Cir. 1990). Disapproval of *Pryzbowski* by your Honorable Court would, of course, be more forceful.

Respectfully submitted,

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INTRODUCTION

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Br. in Opp. App. 11a-12a. Footnote 3 does not express any change in that view. Preceded by the signal word "However," footnote 3 then addresses footnote 7 of the *Pappas II* brief, in which the government stated,

> Different considerations may apply when an HMO, or other managed care entity, uses medical judgment in deciding whether a claim for treatment that has already been provided should be paid. Those are the sorts of decisions that insurance companies make in determining whether payment should be made under a fee-for-service ERISA plan.

Br. in Opp. App. 12a. Footnote 3 then adjusts that view on claims for payment for treatment by stating, "for the reasons given in the text, regardless of whether the claim is made before or after treatment, the better view is that an HMO employee deciding a claim is an ERISA fiduciary."

In addition to missing the point of clarification made in footnote 3, where the government changed only what it said about a claim for payment for treatment, not what it said about the tort claim for bodily injury or contribution damages involved in this case, the petitioner's supplemental brief misconstrues the context in which footnote 3 was written. That footnote was written for *Rush Prudential*, an "analytically different" case, because it deals with the statutorily imposed rules for binding independent review at the option of the claimant versus the sole discretion rules written by the HMO. *Rush Prudential* does not involve the type of tort claim involved in this case.

The government's amicus brief in *Rush Prudential* chose first to speak to whether or not the statute "relates to" ERISA. 00-1021 U.S. Br. 6-11. The "text" to which footnote 3 refers presents the government's explanation that *Pegram* does not alter the government's conclusion that the independent review statute "relates to" ERISA. *Id.*, p. 7-11. What the government appears to have perceived in its *Rush Prudential* brief is simply that *Pegram* should not be read to hold that pure benefit or eligibility determinations do not lose their ERISA fiduciary status every time they may be made by a doctor or may involve some medical consideration.

To that extent, the government's amicus brief in *Rush Prudential* is in harmony with what your Honorable Court's unanimous opinion stated in *Pegram*, that, in considering whether a case involves a claim that is subject to ERISA, the pertinent questions are the capacity in which the HMO employee acted and then the nature of the decision at issue. In particular, your Court first observed that "the threshold question is not whether the actions of some person employed to provide services under a plan adversely affected a plan beneficiary's interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint." *Pegram*, *supra*, 530 U.S. at 226. Next, your Court directed,

> It will help to keep two sorts of arguably administrative acts in mind. Cf. *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995) (discussing dual medical/administrative roles of HMOs). What we will call pure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment. 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patent's condition: given a patient's constellation of symptoms, what is the appropriate medical response?

Pegram, *supra*, 530 U.S. at 227-228.

Furthermore, as your Honorable Court pointed out, pure eligibility decisions include determinations such as "whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged)," *Pegram*, *supra*, 530 U.S. at 228, or "such as whether a plan covers an undisputed case of appendicitis," and "rejecting a claim for no other reason than the HMO's financial condition." *Id.* at 229. Thus, if what the government means to say in its amicus brief in *Rush Prudential* is that such decisions remain pure eligibility decisions even though they are made by

an HMO-employed doctor or involve some medical consideration, the government's brief correctly applies *Pegram*.

The government's amicus brief in *Rush Prudential* is also consistent with your Honorable Court's unanimous pronouncements in *Pegram* to the extent that the brief recognizes that "treatment decisions" or "mixed eligibility and treatment decisions," as defined in *Pegram*, are not ERISA-protected fiduciary decisions when made by an HMO doctor even though that doctor has no traditional physician-patient relationship with the plan participant or beneficiary. Given the limited contour of the case in which the government filed that amicus brief, where the question deals with the procedures under which a payment dispute about an HMO's eligibility decisions can be resolved, the brief's emphasis on "treatment" leaves intact the government's position in *Pappas II*, because the issue is one that implicates a treatment decision made when no genuine question of coverage appears, and yet preserves the point that the government tries to make in *Rush Prudential*, that the statute "relates to" ERISA because it involves "fiduciary" decisions under *Pegram* or the statute at least involves regulation of "the claims resolution processes utilized by ERISA plans". 00-1021 U.S. Br. 10-11.

However, if what the government's amicus brief is meant to suggest is that *Pegram* should be read to restrict the non-fiduciary status of "medical necessity" determinations and similar decisions, such as, "physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition," *Pegram*, *supra*, 530 U.S. at 229-230, to those made only by HMO physicians who have a traditional doctor-patient relationship with the claimant, the government's suggestion runs afoul of what your Court explicitly said in *Pegram*: those decisions are at least "mixed eligibility and treatment decisions,"

Id. "We think Congress did not intend Carle or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians," *Id.* at 231, and "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA," *Id.* at 237. Moreover, your Honorable Court never expressed that limiting distinction in *Pegram*, but rather spoke in terms applicable to all HMOs and their employees. *See* 530 U.S. at 231-232.

What petitioner sees as "crucial" to its petition in footnote 3 of the government's amicus brief in *Rush Prudential* actually undermines petitioner's position. The government has not disavowed the central position which it took in light of *Pegram* in the brief that it filed with the Pennsylvania Supreme Court in *Pappas II*. That position, which views the claim made against the petitioner in this case as a mixed eligibility and treatment decision that is not preempted by ERISA, remains officially unchanged.

II. DISPOSITION OF THE PETITION FOR WRIT OF CERTIORARI

Respondents decline to join with petitioner in the speculation expressed in Part 2 of its supplemental brief as to why no order issued about this case following your Honorable Court's conference on October 26, 2001. Although respondents anticipate that your Court will dispose of the pending petition for writ of certiorari, respondents also decline to join with petitioner in dictating when your Court should make its decision.

Despite the petitioner's chastisement of the respondents' discussion of the merits of this case (Supplemental Brief for Petitioner, p. 1; Reply Brief for Petitioner, p. 2), petitioner's supplemental brief also discusses the merits of the case in urging your Honorable Court to promptly list the case, to grant certiorari to resolve the conflict which the petitioner sees between *Pappas II* and *Pryzbowski*, *supra*, and to persuade the Pennsylvania Supreme Court to "see the error of its ways" and to "abandon its idiosyncratic ways." (*Id.*, p. 6).

Consideration of the merits or circumstances of a case plays an undeniably important role in your Honorable Court's disposition of a petition for writ of certiorari. That is why petitioner's supplemental brief asserts that the Pennsylvania Supreme Court "got it wrong" in *Pappas II* and rendered a decision which draws a line of conflict between the state courts which are obliged to or choose to follow *Pappas II* and the federal courts which are obliged to or choose to follow *Corcoran* and *Pryzbowski*. One cannot make — or refute — such assertions and discuss the "certworthiness" of a case without considering the merits and the circumstances of the case.

Respondents' Brief in Opposition delineated the reasons why the Pennsylvania Supreme Court got it right in *Pappas II*, and there is no need to reiterate those reasons in this brief. Suffice it to say, that the petitioner's supplemental brief, like its petition for writ of certiorari and its reply brief, overlook or attempt to obscure the undeniable fact that this case involves at least a mixed decision or a pure treatment decision as defined in *Pegram*. This is so, because the petitioner was obliged to cover and clearly stated that it would cover emergency care "any time, anywhere," "anywhere in the world," "24 hours a day, 7 days a week," and that "[w]hen a delay would be detrimental to your health, seek the nearest medical attention". Respondents' Pennsylvania Supreme Court Reproduced Record, p. 156a, 157a, 158a. In short, this case does not involve a pure benefits determination that is shielded by ERISA. Rather, it involves a determination which *Pegram* clearly places beyond the ERISA preemption shield that the petitioner seeks to raise to prevent its being held accountable in the type of common place tort-based medical malpractice action which your Honorable Court has always regarded as not having been displaced by ERISA. *See Mackey v. Lanier Collections Agency and Service*, 486 U.S. 825, 833 (1988); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-655 (1995); *Pegram, supra*, 530 U.S. at 235.

In its reply brief, petitioner recognized that "[i]f, for example, the alleged basis for liability of the HMO is that its own personnel committed medical malpractice in the course of treating a subscriber, there is no reason why the malpractice claims need implicate plan administration and no reason why ERISA should preempt them." (Reply Brief for Petitioner, p. 3). Petitioner's belief that respondents in this case are "trying to hold an HMO liable because it will not *pay for* out-of-network services" (*Id.*, emphasis in original) notwithstanding, the claim in this case is that petitioner committed medical malpractice by directing and delaying appropriate treatment. Thus, as stated in their brief in opposition, respondents respectfully suggest that your Honorable Court deny the petition for writ of certiorari.

CONCLUSION

For the foregoing reasons and those advanced in their brief in opposition, respondents respectfully ask that your Honorable Court deny the petition for writ of certiorari. Petitioner's insistence that *Pappas II* presents a conflict with *Pryzbowski* and that your Honorable Court should act swiftly rekindles the respondents' alternative suggestion that your Honorable Court grant the petition for writ of certiorari, summarily affirm *Pappas II* in light of *Pegram*, and note its disapproval of *Pryzbowski* and the other cases which petitioner asserts are in conflict with *Pappas II*.[1]

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1. Petitioner's assertion that *Pappas II* conflicts with *Pryzbowski* makes *Pryzbowski* difficult to reconcile with *Pegram* and with the prior decisions of the Third Circuit in *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995), *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999), and *Lazorko v. Pennsylvania Hospital*, 237 F.3d 242 (3d Cir. 2000). Courts in that circuit could decline to follow *Pryzbowski* on the ground that *Pryzbowski* conflicts with *Pegram*, *Mennan Co. v. Atlantic Mutual Ins. Co.*, 147 F.2d 287, 294 (3d Cir. 1998), or is "without effect," because it is inconsistent with the earlier panel decisions, *Pfieffer v. School Bd.*, 897 F.2d 779, 781 (3d Cir. 1990). Disapproval of *Pryzbowski* by your Honorable Court would, of course, be more forceful.

Respectfully submitted,

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